No. 80-5303

In the Supreme Court of the United States

OCTOBER TERM, 1980

ANTONIA BELTRAN, INDIVIDUALLY AND ON BEHALF OF ALL OTHER SIMILARLY SITUATED, PETITIONER,

v.

BEVERLEE A. MYERS, INDIVIDUALLY AND AS DIRECTOR, CALIFORNIA STATE DEPARTMENT OF HEALTH, RESPONDENTS

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

JOINT APPENDIX

GILL DEFORD
NEAL S. DUDOVITZ
National Senior Citizens Law Center
1636 West 8th Street, #201
Los Angeles, California 90017
Telephone: (213) 388-1381
Attorneys for Petitioners

GEORGE DEUKMEJIAN,
Attorney General
THOMAS WARRINER,
Assistant Attorney General
ANNE S. PRESSMAN,
DONALD A. ROBINSON,
RICHARD J. MAGASIN,
Deputy Attorneys General
3580 Wilshire Boulevard,
Suite 800
Los Angeles, California 90010
Telephone: (213) 736-2214; 2606
Attorneys for Respondent

PETITION FOR WRIT OF CERTIORARI FILED AUGUST 27, 1980
CERTIORARI GRANTED NOVEMBER 3, 1980

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RELEVANT DOCKET ENTRIES

IN THE UNITED STATES DISTRICT COURT FOR THE CENTRAL DISTRICT OF CALIFORNIA:

Complaint in Intervention for Declaratory and Injunctive Relief, filed February 26, 1979

Answer to Complaint in Intervention for Declaratory and Injunctive Relief, Filed March 19, 1979

Order Granting Plaintiffs' Motion for Certification of the Class, filed May 10, 1979

Findings of Fact and Conclusions of Law, filed May 10, 1979

Summary Judgment, filed May 10, 1979

IN THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT:

Opinion, filed May 14, 1980

Order Denying Rehearing, filed July 30, 1980

UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA

No. C 78 -2350 MML(Sx)

ROSSYE DAWSON, INDIVIDUALLY AND ON BEHALF OF ALL OTHERS SIMILARLY SITUATED, PLAINTIFF

vs.

EDWARD BEACH, ET AL., DEFENDANTS.

ANTONIA BELTRAN AND ENOSINSIO MANAHAN, INDIVIDUALLY AND ON BEHALF OF ALL OTHERS SIMILARLY SITUATED, INTERVENOR-PLAINTIFFS.

COMPLAINT IN INTERVENTION FOR DECLARATORY AND INJUNCTIVE RELIEF FILED FEBRUARY 26, 1979

CLASS ACTION

INTRODUCTION

1. This class action challenges the failure of the State of California to provide Medicaid benefits (referred to in California as "Medi-cal") to individuals otherwise eligible because of the State's application of an additional eligibility requirement which does not comport with controlling federal law.

JURISDICTION

2. Jurisdiction is invoked pursuant to 28 U.S.C. § 1343 (3) and (4), which provide for original jurisdiction of this court over actions authorized by 42 U.S.C. § 1983 to redress the deprivation of rights under color of state law. Jurisdiction is also conferred by 28 U.S.C. § 1331, as there is more than $10,000 in controversy; an actual controversy

does exist and plaintiff seeks a declaration of rights pursuant to the Declaratory Judgment Act, 28 U.S.C. §§ 2201, 2202.

PARTIES

3. Intervenor-plaintiff ANTONIA BELTRAN is an eighty-six (86) year old resident of Los Angeles, California, who requires, and who, because of physical frailty, will continue to require, long-term care in a nursing home facility.

4. Intervenor-plaintiff ENOSINSIO MANAHAN is an eighty-five (85) year old long term care patient living in a convalescent home in Anaheim, California. Because of age-related, severe illness, he requires and will continue to require long-term care in a nursing home facility.

5. Defendant EDWARD BEACH is the former Director of the State Department of Health Services, and pursuant to Rule 25(d)(1), F.R.Civ.P., his successor is automatically substituted as a party. His successor and the present Director of the State Department of Health Services is Beverly A. Myers, and as Director she is responsible for the overall administration of the Medi-Cal Program.

6. Defendant BRUCE YARWOOD is the Deputy Director of the State Department of Health Services and is in charge of the Medi-Cal Division of the Department.

CLASS ACTION ALLEGATIONS

7. Intervenors Beltran and Manahan bring this action on their own behalf and, pursuant to Rules 23(c) and 23(b)(2) of the Federal Rules of Civil Procedure, as the representatives of a class consisting of all aged, blind, and disabled individuals who have been, are being, or will be, denied Medi-Cal benefits because of an alleged transfer of assets for inadequate consideration pursuant to Welfare and Institutions Code ("W.&I.C."), Section 14015, and 22 Cal. Admin. Code § 50409. The class is so numerous that joinder of all its members is impracticable. There are questions of law and fact common to the class. Intervenors' claims are typical of the claims of all class mem-

bers, and intervenors will fairly and adequately protect the interests of the class. In addition, defendants have acted and continue to act on grounds generally applicable to all members of the class, thereby making appropriate declaratory and injunctive relief with respect to the class as a whole.

STATUTORY AND REGULATORY FRAMEWORK

8. The Medical Assistance Program (referred to generally as "Medicaid") is a cooperative federal-state program established pursuant to Title XIX of the Social Security Act, 42 U.S.C. § 1396, *et seq*. In accordance with the Act, the Secretary of the Department of Health, Education and Welfare promulgates regulations which, in addition to the statutes, provide the framework in which the states must develop and operate their Medicaid programs.

9. California has chosen to participate in the Medicaid program, and, consequently, the responsible state agency, the State Department of Health Services, is required to administer the program in compliance with federal standards.

10. Among the categories of individuals who, if they meet income eligibility guidelines, are eligible for Medicaid, are the aged (over 65), blind, and disabled.

11. Under federal law, all recipients of Supplemental Security Income ("SSI"), the federal cash benefit program for the needy aged, blind and disabled, are automatically eligible for Medicaid benefits. These eligibles are known as the "categorically needy." (Certain other groups, not here involved, are also among the categorically needy.)

12. In addition, states have the option, pursuant to 42 U.S.C. § 1396a(a)(10)(C), of providing Medicaid benefits to individuals who meet the categorical definitions (i.e., aged, blind or disabled) but who are not financially eligible. Known as the "medically needy", they may gain eligibility for Medicaid by spending down on medical needs to the eligibility level. California has a medically needy program for its aged, blind and disabled.

13. In the SSI program, the transfer of assets prior to application for less than full consideration is not a relevant factor in determining eligibility.

14. Under California law, transfer of property for less than adequate consideration is specifically noted as an exception to the rule that the provision of health care will not be restricted by property holdings. Under W.&I.C. § 14015,

> any transfer of the holdings by gift or, knowingly, without adequate and reasonable consideration, shall be presumed to constitute a gift of property with intent to qualify for assistance and such act shall disqualify the owner for further aid for a period determined under standards established by the director . . . .

15. The state regulations implementing this provision provide, *inter alia*, that:

> To overcome the presumption, the applicant or beneficiary has the burden of establishing by objective facts, rather than statement of subjective intent, that this presumption is not correct. The applicant or beneficiary shall provide evidence that adequate resources were available at the time of the transfer of property for support and medical care considering such things as the applicant's or beneficiary's age, health, life expectancy, and ability to understand the extent of resources.
>
> (A) The declaration of another purpose, such as to avoid probate, by itself, shall not be sufficient to overcome the presumptions. A showing that the sole purpose of the transfer was for reasons other than to establish eligibility or to reduce the share of cost shall be supported by evidence such as that specified above.
>
> (B) The establishment of the fact that the applicant or beneficiary did not have specific knowledge of the availability of genefits of the Medi-Cal program is not sufficient to overcome the presumption.22 Cal.Admin.Code § 50409(b)(2).

16. Once a determination is made that a transfer was effected improperly,

there shall be a period of ineligibility. This period shall be the time during which the net market value of the property at the time of transfer, less consideration received, would have supported the applicant or beneficiary and the applicant's or beneficiary's family.

22 Cal.Admin.Code § 50411(a).

FACTUAL STATEMENT

17. Intervenor Antonia Beltran requires long-term care in an institutional setting, and is expected to continue to require such care for the indefinite future. She lived in her own home with her husband, Philip, until March, 1978, when her overall weakness required her to go to a convalescent home. She has remained in convalescent homes since that time, and is presently living in the Santa Teresita extended care facility in Duarte, California.

18. On February 23, 1977, she and her husband, Philip, grant-deeded their home in East Los Angeles to their three children, Philip, Emilio, and Josephine. The deed was recorded on March 7, 1977. After deeding the home, they continued to live in it until Mrs. Beltran was forced to leave in March, 1978. Mr. Beltran has continued to live in the home to this day. In May, 1977, both of them were found eligible for Medi-Cal under the state's medically needy program.

19. In the summer of 1978, Antonia Beltran was notified that her Medi-Cal would be terminated. It was terminated effective September 1, 1978, and she has not received Medi-Cal benefits since that time. Her husband, Philip, has continued to receive Medi-Cal benefits.

20. In the fall of 1978, Mrs. Beltran applied again for Medi-Cal benefits. This application was denied in a Notice of Action dated January 8, 1979. A copy of that Notice of Action is attached to this complaint as Exhibit "A".

21. The Notice of Action indicates that the Beltrans' transfer of property in the winter of 1977 is the cause of this denial. According to the Notice of Action, unless certain other conditions are met, Mrs. Beltran will remain in-

eligible for Medi-Cal for the next eight hundred eighty-five (885) months, a period of more than 71 years.

22. Intervenor Enosinsio Manahan is an eighty-five (85) year old long-term care patient living at the Fountainbleau Convalescent Home, 3415 West Ball Road, Anaheim, California. Because of advancing diabetes mellitus and senile dementia, he requires long-term care in an institutional setting and is expected to continue to require such care for the indefinite future.

23. Mr. Manahan entered the convalescent home in January, 1977, and since then has been separated and living apart from his wife, Lucy Manahan. Mrs. Manahan resides with her daughter by a previous marriage, Mrs. Lucille Tom, to whom she pays monthly rent.

24. On April 12, 1978, application for Medi-Cal was made on Ensinsio Manahan's behalf by his step-daughter, Mrs. Lucille Tom, at the Orange County Department of Social Services.

25. On June 5, 1978, the Orange County Department of Social Services denied Medi-Cal eligibility for Enosinsio Manahan, on the grounds of a transfer of assets for inadequate consideration pursuant to Welfare and Institutions Code § 14015 and 22 Cal. Admin. Code § 50409. This denial was based on sale of the family home by Mrs. Manahan in May, 1977, four months after Enosinsio Manahan entered the convalescent home and eleven months before the application for Medi-Cal was made. (Exhibit "B", attached to the complaint.)

26. On July 6 and 7, 1978, a Fair Hearing was held on whether Orange County correctly denied Mr. Manahan's application for Medi-Cal benefits because of its determination that he transferred property in order to become eligible.

27. The Hearing Officer recommended that Orange County rescind its denial of the claimant's Medi-Cal application and that Mr. Manahan be allowed to spend down $1,630.98 in order to meet the property limit for Medi-Cal. (Exhibit "C", attached to the complaint.)

28. On January 12, 1979, the Director of the State Department of Health Services overturned the decision of the hearing officer, and ruled that Orange County correctly applied Section 50409(b) in denying Mr. Manahan's Medi-Cal application. The Director ruled that Mr. Manahan received a community property share from the proceeds of the sale of the home, and that he has not overcome the presumption that the transfer of property was for the purpose of establishing eligibility. (Exhibit "D", attached to the complaint.)

29. The present outstanding balance to the nursing home for cost of his care is $8,944.93.

IRREPARABLE INJURY

INADEQUACY OF REMEDY AT LAW

30. Defendant's determination that plaintiff-intervenors are ineligible for Medi-Cal benefits has caused them irreparable harm, and continues to cause them irreparable harm, in that they are incapable of paying for the cost of necessary institutionalized care with their own incomes. Without Medi-Cal benefits, they will be forced to leave the institution.

31. There is no adequate remedy at law. Defendants are depriving intervenors and their class of necessary health care, and this harm is not susceptible of redress by a mere award of money damages. Only injunctive relief can insure the provision of health care to intervenors and their class.

FIRST CAUSE OF ACTION

32. California has chosen to provide Medi-Cal benefits automatically to all recipients of SSI.

33. The SSI program does not predicate eligibility on a transfer of assets for adequate consideration prior to application. In order to meet the requirement that it provide Medi-Cal benefits to all SSI recipients, California cannot utilize a transfer of assets provision for its categorically needy program.

34. Pursuant to section 1902(a)(10)(C)(i) of the Social Security Act, 42 U.S.C. § 1396a(a)(10)(C)(i), a state is precluded from applying more restrictive eligibility conditions to the medically needy than the categorically needy.

35. Additionally, federal regulations require that a state use resource standards equal to the higher of the state's standards in the Aid to Families with Dependent Children (AFDC) or SSI programs. 42 C.F.R. § 435.840(a), at 43 Fed. Reg. 45216 (September 29, 1978). [In the September 29, 1978, Federal Register, HEW reworded and recodified, but with no substantive changes, all of its Medicaid regulations. 43 Fed. Reg. 45716, *et seq.* Title 42 C.F.R. § 435.840(a) is equivalent to the former 42 C.F.R. § 448.3(c)(1)(iv), which was itself previously codified at 45 C.F.R. § 248.3(c)(1)(iv).]

36. By requiring that assets be transferred for adequate consideration in order to be eligible for Medi-Cal, defendants are applying an eligibility condition more restrictive than that utilized in the SSI program, and thereby are in violation of federal statutory and regulatory requirements.

SECOND CAUSE OF ACTION

37. Pursuant to 42 U.S.C. § 1396a(a)(17), states are permitted to consider only income and resources which are actually available to the recipient. By deeming the value of a former property available to them when in fact neither that property nor its cash value is available, defendants are violating this federal requirement

THIRD CAUSE OF ACTION

38. By requiring applicants to demonstrate that they disposed of assets for adequate consideration prior to application, defendants have added an additional eligibility condition which is nowhere found in the Social Security Act. Such additional eligibility conditions are in violation of the Supremacy Clause of the Constitution.

FOURTH CAUSE OF ACTION

39. Section 50409 of Title XXII, California Administrative Code, represents a conclusive presumption that any transfers of assets within a two-year period prior to application are for the purpose of qualifying for aid. Section 14015, W.&I.C., conclusively presumes that any transfer for inadequate consideration is for the purpose of obtaining Medi-Cal benefits. There is no realistic opportunity to rebut these presumptions, as section 50409(b)(2) of the California Administrative Code does not permit any proof of "subjective intent." There is no logical nexus between the basic fact of the transfer for inadequate consideration and the presumed fact of transfer to obtain benefits.

FIFTH CAUSE OF ACTION

40. The transfer of assets rule has created two classes of aged, blind and disabled individuals. One class consists of those aged, blind and disabled who are automatically eligible for Medi-Cal benefits without regard to any transfer of assets that they may have made prior to applying for Medi-Cal. The other class consists of those aged, blind and disabled who, like the first class, are in need of health care but who are not eligible for SSI benefits and are therefore subject to the transfer of assets rule in applying for Medi-Cal. This classification is arbitrary and irrational, and serves no legitimate purpose. It is contrary to a major goal of the Medicaid program, to provide health care to needy aged, blind and disabled individuals unable to pay for their own care. Such arbitrary and irrational classifications violate the equal protection clause of the 14th Amendment.

PRAYER FOR RELIEF

WHEREFORE, intervenors respectfully pray on behalf of themselves and all others similarly situated that this Court:

1. Assume jurisdiction over this case.

2. Certify by order at an appropriate time that this suit is properly maintainable as a class action pursuant to Rule 23(b)(2) of the Federal Rules of Civil Procedure.

3. Declare that defendants' policy of terminating Medical eligibility due to an alleged transfer of assets without adequate consideration prior to applying for Medi-Cal, as expressed in W.&I.C. § 14015 and 22 Cal.Admin.Code § 50409, violates controlling federal law and implementing regulations, and the equal protection and due process clauses of the Fourteenth Amendment to the United States Constitution.

4. Enter a permanent injunction restraining defendants, their successors in office, agents, and employees, and all persons acting in concert with them, from denying Medi-Cal benefits to the intervening plaintiffs and all members of their class for the reason that they allegedly transferred assets prior to application without due consideration.

5. Order defendant to notify all members of the class that their ineligibility for Medi-Cal due to a transfer of property without due consideration has been re-evaluated and that if they are otherwise eligible: (1) they may reapply for Medi-Cal without regard to any previous transfer of assets; and (2) that they may request reimbursement for these amounts which they were forced to spend on medical care during the period of ineligibility based on a transfer of assets which would otherwise have been covered by Medi-Cal.

6. Award intervenors the costs of this suit, including reasonable attorneys fees.

7. Grant such other and further relief as to the Court seems just and proper.

DATED: February 8, 1979.

Respectfully submitted,

DANIEL HANTMAN
IRENE CARDEANS GALLARDO
PAUL HENRY ABRAM
RONALD L. TAYLOR
RICHARD ROSS
GARY ROWSE
GILL DEFORD
NEAL DUDOVITZ
STUART PARKER

By _____
GILL DEFORD
Attorneys for Plaintiffs

MEDI-CAL
NOTICE OF ACTION
DENIAL/DISCONTINUANCE
OF BENEFITS

Medi-Cal Central District #80
1801 W. Valley Blvd.
P.O. Box 2630
Alhambra, CA 91803

Antonia Beltran
% Philip Beltran
1111½ So. Lorena St.
Los Angeles, CA. 90023

State No. 5243322
District: 80
Denial/discontinuance for:
Antonia Beltran

We have reviewed all information available to us about your circumstances, and we find that:

☒ Your application for Medi-Cal dated 10/27/78 has been denied.

☐ Your eligibility to receive Medi-Cal will be discontinued effective the last day of _____.
(Month)

The reason for this denial/discontinuance is: the value of the property you transferred on 3-7-77 causes your property reserve to exceed the allowable maximum. You are ineligible for a period of 285 months, or until you have spent the excess value of $22,121,000 in medical bills. Your period of ineligibility will also expire if your property is returned to you or if you receive fair price for the property you transferred.

☐ You did not return your completed RECORD OF HEALTH CARE COSTS form for _____
(Month)

and so did not receive a Medi-Cal card. We will assume that you wish to have your Medi-Cal eligibility discontinued unless you request a RECORD OF HEALTH CARE COSTS form for _____ (Month) from this office by _____ (date). If we do not hear from you, your eligibility will be discontinued effective the last day of _____ (Month).

The regulations which require this action are California Administrative Code, Title 22, Section(s): 50411.2.24

EXHIBIT "A"

PERIOD OF INELIGIBILITY

If you are eligible for Medicare and your Medi-Cal eligibility is discontinued, this means that _____ is the
(Month)
last month the State will pay your premium for supplementary insurance coverage (Part B Medicare). You will receive a written notice from the Social Security Administration, or you may call your Social Security District Office if you have any questions about your Medicare status.

If you have any questions about this action or if there are additional facts relating to your circumstances which you have not reported to us, please write or telephone. We will answer your questions or make an appointment to see you in person. Please remember that this action pertains only to the circumstances you reported to us, and that you may reapply at any time.

T Live	576-1261	1-8-79
(Eligibility Worker)	(Phone)	(dated)

EXHIBIT "A"

MEDI-CAL
NOTICE OF ACTION
DENIAL/DISCONTINUANCE
OF BENEFITS

HUMAN SERVICES AGENCY/
SOCIAL SERVICES
1624 W. 19th STREET
P.O. Box 1999
SANTA ANA, CALIFORNIA 92702

Enosinsio Manahan
15261 Swallow Lane
Westminster, Ca. 92683

State No. 3013-0315454
District: 09
Denial/discontinuance for:
MANAHAN, Enosinsio

We have reviewed all information available to us about your circumstances, and we find that:

☐ Your application for Medi-Cal dated 4/12/78 has been denied.

☐ Your eligibility to receive Medi-Cal will be discontinued effective the last day of _____.
(Month)

The reason for this denial/discontinuance is: A period of ineligibility exists starting 5/77 and are allowing expenditures from transferred property at the rate of the State maintenance Needs of $278. This accounts for approx. $3600. of the transferred property for the period 5/77-5/78. Therefore, as of 6/78 we have determined the remainder of monies transferred without adequate consideration to be $50,342. based on the information you provided on proceeds from sale of your home. (see attached.)

☐ You did not return your completed RECORD OF HEALTH CARE COSTS form for _____ and
(Month)
so did not receive a Medi-Cal card. We will assume that you wish to have your Medi-Cal eligibility discontinued unless you request a RECORD OF HEALTH CARE COSTS form for _____ from this
(Month)
office by _____. If we do not hear from
(Date)
you, your eligibility will be discontinued effective the last day of _____.
(Month)

EXHIBIT "B"

The regulations which require this action are California Administrative Code, Title 22, Secton(s): 50409, 50096,50411

If you are eligible for Medicare and your Medi-Cal eligibility is discontinued, this means that_____
(Month)
is the last month the State will pay your premium for supplementary insurance coverage (Part B Medicare). You will receive a written notice from the Social Security Administration, or you may call your Social Security District Office if you have any questions about your Medicare status.

If you have any questions about this action or if there are additional facts relating to your circumstances which you have not reported to us, please write or telephone. We will answer your questions or make an appointment to see you in person. Please remember that this action pertains only to the circumstances you reported to us, and that you may reapply at any time.

Patty Fleming	834-6152	6-5-78
(Eligibility Worker)	(Phone)	(Dated)

MANAHAN, Enosinsio
3013-0315454

Medi-Cal Notice of Action

You will not be eligible until these monies are expended at a rate of $25.00 per month for Mr. Manahan, plus $253.00 per month for Mrs. Manahan, plus substantiated medical expenses.

EXHIBIT "B"

CALIFORNIA DEPARTMENT OF
HEALTH SERVICES

Fair Hearing No. 78163110 OR
State No. 30-13-315454
District

03 030 01 1

IN THE MATTER OF THE HEARING OF CLAIMANT
ENOSINSIO MANAHAN
15261 Shallow Lane
Westminister, CA 92683

Hearing Officer: ERNESTO J. PEREZ
Country Representative: JOHN JACOBS
Authorized Representative: TIM FLYNN
Place: Santa Ana, California

Date of Hearing: July 6 & 7, 1978*
Date of County Notice: June 5, 1978
Fair Hearing Filing Date: June 8, 1978
Air Paid Pending: N/A (Denial Action)

PROPOSED DECISION

ISSUE

The issue for resolution is whether Orange County correctly denied the claimant's April 12, 1978 application for Long-Term Care California Medical Assistance Program (Medi-Cal) benefits because of its determination that he transferred property in order to become eligible.

STATEMENT OF FACT

COUNTY ACTION AND POSITION:

Orange County took the above-action after determining that the claimant's community property share of the

* Record left open until July 28, 1978 for the claimant to submit additional documents. Such information was received, and the record was closed on August 15, 1978. The county did not submit rebuttal evidence.

EXHIBIT "C"

$75,000 proceeds from the sale of his home in May 1977 had been transferred for the purpose of establishing program eligibility. In evaluating the disposition of the $75,000, the county accepted the following transactions as acceptable dispositions:

1. Claimant's medical expenses	$ 8,381.88
2. Spouse's medical expenses	2,240.14
3. Claimant's and spouse's personal expenses	5,466.68
4. Burial plots for claimant and spouse	1,969.10
TOTAL:	$18,057.80

After allowing the $18,057.80 expense, Orange County identified $56,942.20 as the community property remaining from the sale of the home ($75,000.00—$18,057.80 = $56,942.20. The remainder was then halved to determine the claimant's community property share from the proceeds of the sale of his home (½ × $56,942.20 = $27,648.65). As the claimant declared ownership of a $2,999.96 savings account in his own name on the date of application, the county contends that he has failed to verify the disposition of $24,648.69 remaining from his share from the transfer of his home. Inspection of that account by the Hearing Officer established that the monies are under the name of the claimant's spouse and her daughter (not adopted by claimant). Since that transfer (creation of accounts and expenditures therefrom) occurred within two years of this application it is Orange County's position that according to Title 22, California Administrative Code (CAC), Section 50400(b) the claimant now has the burden of demonstrating by objective facts (rather than by statements of objective intents) that he did not dispose of $24,648.69 for the purpose of establishing program eligibility. Assuming that the claimant is unable to overcome the presumption that he transferred his funds in order to establish program eligibility, the county stated that since he is currently in long-term care status he will become eligible for program participation at that point when a $25 monthly maintenance allowance (plus verified paid medical expenses) reduces his property

holdings below the $1,500 limit for a one-person Medi-Cal Family Budget Unit (MFBU).

Orange County rejected the claimant's Authorized Representative (AR) argument that the $75,000 proceeds from the sale of his home were the separate property of his spouse. The county stated that although the purchase of that property may have initially been made possible as the result of a gift or loan of money from the claimant's spouse's mother directly to her daughter, the claimant's spouse's testimony at the hearing established that these monies were repaid by the claimant's spouse during their marriage from the claimant's spouse's earnings. The county therefore reasoned that property obtained during the marriage by use of a community property fund (earned income) becomes community property and is no longer the separate property of either spouse. Additionally, the county pointed out that the only property which it alleged to be owned by the claimant was the real property sold in 1977, in which the claimant was recorded by title deed as a joint tenant in conjunction with his spouse.

Orange County refused to allow $18,476 expenditures as reductions of the claimant's personal property holdings which the claimant's spouse's daughter claimed to have been paid from the May 1977 property sale proceeds for "loan commitments." The county explained that affidavits submitted to establish the occurrence of these transactions are not sufficient to show that they were transfers to satisfy legal debts because of the following:

1. All transactions were between the claimant and friends or relatives. The county submits that where the relationships of contracting parties are personal, the requirements of Title 22, CAC, Section 50409(b) impose a high standard of proof to establish that the transactions were legally valid. Absent pre-existing evidence regarding how the obligations were incurred by the claimant, the county submits that mere written statements by those who received funds are insufficient;

2. The affidavit by the claimant's spouse's daughter stating that she was paid $1,000 does not indicate what the $1,000 was paid for;
3. The affidavit stating that the claimant's spouse's son-in-law was repaid $2,176.10 fails to indicate what the money was owed for and how it was originally provided; and that
4. Three affidavits accounting for the receipt of $15,300 are vague as to when the monies or services were provided. Additionally, Orange County argued that the fact that one affidavit is undated and the other two are dated after April 19, 1978, establishes that no previously-existing debts actually occurred between these recipients and the claimant.

Notwithstanding its position that the $18,476 paid to the claimant's spouse's daughter, the claimant's spouse's son-in-law, and three other friends or relatives was not a transfer to satisfy a legal debt, the county pointed out that even had it acknowledged such an amount as a valid disposition of the claimant's property, his remaining holdings still render him ineligible for current enrollment in the Medi-Cal program ($27,648.65–$18,476.00 = $9,172.65).

No evidence was introduced to show that the county completed an eligibility evaluation or advised the claimant of qualification by spenddown.

CLAIMANT'S POSITION:

The claimant's AR contended that Orange County had incorrectly treated $37,500 from the sale of a home in May 1977 as the claimant's community property share. He argued that the claimant had no community property share in that property because it represented a 1963 transfer of $7,500 paid to the claimant's spouse by her mother as a partial inheritance and for the services rendered to her by her daughter.

Alternatively, it was argued that the family had properly accounted for the disposition of the claimant's interest in the proceeds from the May 1977 sale.

Records and deeds were submitted to show the following disposition of the $75,000:

1. Proceeds from home: Gross Sales Price (Contract price plus taxes)		$75,403.43
2. Less Closing Costs		
a. Settlement charges		$ 542.25
b. Payoff of second mortgage		9,421.59
c. Interest for second mortgage payoff		53.99
d. Statement fee	+	15.00
e. Reconveyance fee		25.00
		($10,057.83)
3. Cash due (1-2)		− 10,057.83
		$65,345.60

Of the remaining cash due ($65,345.60), $25,000 was received in the form of a second trust deed on the property, payable to the claimant's spouse and her daughter as joint tenants and as their sole and separate property. The terms of the trust deed note provide that 3 percent interest will be paid annually and that monthly installments of not less $225 for a period of ten years shall be paid against the principal. On February 6, 1978, this trust deed was transferred to the claimant's spouse's daughter as her separate property. In reviewing a title search abstract provided by the Title Search Section of the Los Angeles County Department of Public Social Services, the record indicates that the $25,000 trust deed is a product from the sale of the claimant's property in May 1977 in which he held a joint tenancy with his spouse.

The AR argued that the $25,000 second trust deed should be excluded from consideration as the claimant's property because it represents the legacy which the claimant's spouse and her previous spouse intended for the claimant's non-adopted stepdaughter. The basis for this contention was testimony at the hearing by the claimant's

spouse and her daughter, but no documentary evidence (such as wills, letters, etc.) was provided.

Assuming the $25,000 is properly excluded, the AR then argued that the outstanding amount to be accounted for is $40,345.60 ($65,345.60 balance from home sale proceeds—$25,000.00 second trust deed). The claimant's spouse and her daughter testified that the remainder has been disposed of as follows: (Note: These are the transactions which Orange County has labeled unacceptable "loan commitments".)

1. Loan repayment to George Tom (spouse of claimant's spouse's daughter): $2,176.01

   Both testified that the claimant's spouse's daughter and her husband have assisted the claimant and his spouse since 1960 when the claimant retired. They explained that the claimant and his spouse only had Social Security income of about $3,600 annually plus whatever the claimant's spouse could earn by sewing. The claimant's spouse's daughter said that she and her husband helped pay: (1) the claimant's and his spouse's property taxes (which were up to $2,400 per year prior to the May 1977 sale), (2) medical expenses, (3) food and (4) miscellany. She said that because of the claimant's limited income, other members of the family also helped out during the last fifteen years.

   To prove that the money paid to the son-in-law was reimbursement for benefits received by the claimant and his spouse, cancelled checks written from January 21, 1977, through March 22, 1978 were introduced totalling $2,411.05. These checks were written by George Tom and made payable to the county tax assessor ($1,344.01), ambulance service companies ($240.40), doctors ($549.00), utility companies ($231.84) and miscellaneous ($45.80).

2. Loan Repayment to Lucille Tom: $1,000.00

   The claimant's spouse testified that her daughter (Lucille Tom) has helped her since the claimant retired.

EXHIBIT "C"

To show that the payment of this money was for an equal value of benefits received by the claimant, bank records were submitted to establish that on May 19, 1977, Lucille Tom made a $1,000 payment to Union Federal Savings as part of the closing costs on the sale of the claimant and his spouse's home. A review of the bank records by the Hearing Officer found that the account from which payment by Lucille was made was a joint account, in which the claimant's spouse was the other member. This account (#144374) was opened on May 16, 1977, with a deposit of $37,845.60 from the proceeds of the sale of the home. On April 25, 1978, its balance was $262.01.

3. Loan Repayment to Sidney Loquet: $10,000.00

The claimant's spouse testified that the above is her nephew and that she raised him after he became an orphan. She explained that because of her care she believed that Mr. Loquet had felt a moral obligation to assist her and her spouse when he became an adult. This help was received by Mr. Loquet paying for an eye surgery operation, clothing and insurance at the rate of about $20 monthly over a 15-year-period. The claimant's spouse's daughter said that she believed Mr. Loquet had provided at least $10,000 in benefits during the past. No other evidence was introduced to document the claimant and his spouse's indebtedness to Mr. Loquet.

4. Payment for services rendered by Ernest Orozco: $3,300.00

The claimant's spouse explained that Mr. Orozco (the claimant's spouse's nephew) worked for her and her spouse for 9 months (August 1976 through April 1977) as a caretaker of their home. She said that he maintained the yard, drove the claimant to the doctor, and house-sat. His services included painting the house, stripping the floors, and generally getting it into condition for sale. She stated that it was agreed that he

would be paid about $3,000 for his work when he started.

5. Loan repayment to Gertrude Podolinski: $2,000.00

The claimant's spouse testified that Ms. Podolinski (her niece) has provided benefits during the past to the claimant by paying insurance premiums and gifts. To document this obligation, cancelled checks were submitted. Those checks totalled 14 in number, written during the period for December 10, 1972 through January 16, 1977, and ranging in amounts from $10 to $200 per check (totalling $530 in all). Four of the checks are marked "gift" by Ms. Podolinski, and four are marked "insurance". Those marked "insurance" total $95.

TOTAL DISPOSITION BY LOAN REPAYMENT
(1 + 2 + 3 + 4 + 5) $18,476.01

Deducting the above expenditures, the AR contends results in a remaining property from the home sale proceeds of $21,869.59 ($40,345.60 balance from home sale proceeds—$18,476.01). By then deducting the $18,057.80 expenditures accepted by the county at the hearing, the amount remaining to be accounted for is $3,811.79 (21,869.59—$18,057.80), of which half must be deducted to preserve the claimant's spouse's community property share. When that halving occurs, the amount of the claimant's property remaining unaccounted for is $1,905.89 (½ × $3,811.79).

The Hearing Officer would like to note that his review of all documents and materials submitted at the hearing establish that the claimant is 84 years of age and has been in a nursing home since January 1977. According to his spouse's testimony, he concurred with her decision to sell their home in 1977, but she executed all the legal papers pursuant to a power of attorney which she has held for him since 1963. The claimant's signature does not appear in the sale of his home in 1977, on the transfers of the $25,000 trust deed, nor on any of the checks written from the account established from the proceeds of the 1977 sale. Addi-

tionally, a medical evaluation completed on July 5, 1978 by a medical doctor and a psychiatrist diagnose the claimant as having severe Dementia since December 1976. The psychiatrist reported: (1) that the claimant's ability to "comprehend and follow instructions" is "poor" (the lowest capacity rating provided in his reporting form), (2) severe memory defect, (3) moderately severe orientation defect, (4) moderately severe autistic or regressive behavior, (5) moderately severe illogical association of ideas, and (6) severe judgment defect, with no improvement expected. The medical doctor first saw the claimant on January 28, 1977, and his most recent examination was on July 1, 1978. June 30, 1978 was the date of the most recent psychiatric examination.

FINDINGS OF FACT

Since January 1977, the claimant has lacked a mental capacity to transact legal business. This finding is based on a review of the medical reports described in the Statement of Facts. Additionally, it is found that except for his oral agreement with his spouse in early-1977 that she should sell their home, he has not participated in making any decisions about the disposition of his property. This finding is based on the claimant's spouse's testimony and a review of all the documentary evidence—including the title deeds, trust notes, and cancelled checks—none of which contain the claimant's signature. It should be noted that even were his signature present on some of the documents executed since the sale of his home, the significance of such occurrence would have to be weighed in light of the medical doctor's evaluation which describes the claimant as having been severely demented since December 1976.

CONCLUSIONS OF LAW

I

Title 22, CAC, Section 50420 states that the property reserve of a one-person MFBU shall not exceed $1,500.

Title 22, CAC, Section 50403 requires that the separate property and community property share of any person included in the MFBU shall be evaluated in determining Medi-Cal eligibility. Subsection (b)(4) excludes from consideration the separate and share of community property of a person who is not included in the MFBU due to Long-Term Care (LTC) status.

CONCLUSION 1:

Following the sale of the claimant's home in May 1977, his community property share was $32,672.80. This figure is reached as follows:

A. Gross Sales Price:	$75,403.43
B. Less Closing Costs and Pay-Off of Prior Mortgage:	– 10,057.83
C. Community Property Value from Sale of Home (A–B):	$65,345.60
D. Claimant's Community Property Share (½ of C):	$32,672.80

Deducting the $1,500 exemption, the claimant held $31,172.80 in property to be accounted for.

II

Title 22, CAC, Section 50408(a)(2)(A) provides that transfers of property shall not result in ineligibility where the transfer was to satisfy a legal debt.

CONCLUSION 2:

From the $31,172.80 community property share of the proceeds from the sale of his home in May 1977, $13,749.77 must be disregarded as dispersals for the satisfaction of legal debts, leaving $17,423.03 to be accounted for. This conclusions was reached as follows:

EXHIBIT "C"

ALLOWABLE EXPENDITURES
(TO SATISFY LEGAL DEBTS)

	AMOUNT
1. Claimant's own medical expenses (accepted by county)	$ 8,381.88
2. ½ of the personal expenses of the claimant and his spouse that were accepted by the county	2,733.34
3. ½ of expense for common burial plot	984.55
4. ½ of payment to Ernest Orozco for services rendered from August 1976 through April 1977. This expense is accepted by the Hearing Officer as a legal debt based on the following: (a) the claiment's spouse's testimony that Mr. Orozco performed his tasks pursuant to an agreement that he would be paid, (b) the cancelled check showing payment, and (c) the receipt signed by Mr. Orozco indicating the payment was accepted for services he had rendered.	1,650.00
TOTAL:	$13,749.77

III

Title 22, CAC, Section 50406: Transfer or conversion of property may affect eligibility. See Sections 50407 through 50411.

50408. Transfer of Property Which Does Not Result in Ineligibility.

(a) Transfer of property shall not result in ineligibility for Medi-Cal under any of the following conditions:

(1) The net market value of the property transferred, when included in the property reserve, would not result in ineligibility. The determination of value shall be made as of the time of transfer. If eligibility exists, the value of the property shall no longer be considered.

EXHIBIT "C"

(2) Adequate consideration is received. Adequate consideration includes:

(A) A transfer which was to satisfy a legal debt.

(B) A transfer which was to reimburse someone other than a responsible relative, as specified in Section 50351, for care or benefits provided on the basis of an agreement or understanding that reimbursement would be made. The applicant or beneficiary shall provide evidence that clearly establishes that the value of the care or benefits provided was reasonably equivalent to the value of the property transferred.

(3) Foreclosure or repossession of the property was imminent at the time of transfer, and there is no evidence of collusion.

(4) The transfer was made in return for an enforceable contract for life care which does not include complete medical care. In this case, each full item of need provided under the life care contract shall be considered income in kind in accordance with Section 50509.

(b) There is a presumption that property transferred by the applicant or beneficiary more than two years preceding the date of initial application was not transferred to establish eligibility or reduce the share of cost. Such property shall not be considered in determining eligibility, unless there is evidence that conflicts with this presumption.

50409. Transfer of Property Which Results in Ineligibility

(a) Transfer of property shall result in ineligibility for Medi-Cal if the transfer did not meet one of the conditions specified in Section 50408 or the transfer was in return for an enforceable life care contract which includes complete medical care.

(b) Transfer of property without adequate consideration shall result in ineligibility for Medi-Cal if the transfer was made to establish eligibility or to reduce the share of cost.

EXHIBIT "C"

(1) It shall presumed that property transferred without adequate consideration was for the purpose of establishing eligibility or to reduce the share of cost as limited by (2).

(2) To overcome the presumption, the applicant or beneficiary has the burden of establishing by objective facts, rather than statement of subjective intent, that this presumption is not correct. The applicant or beneficiary shall provide evidence that adequate resources were available at the time of the transfer of property for support and medical care considering such things as the applicant's or beneficiary's age, health, life expectancy, and ability to understand extent of resources.

(A) The declaration of another purpose, such as to avoid probate, by itself, shall not be sufficient to overcome the presumption. A showing that the sole purpose of the transfer was for reasons other than to establish eligibility or to reduce the share of cost shall be supported by evidence such as that specified above.

(B) The establishment of the fact that the applicant or beneficiary did not have specific knowledge of the availability or benefits of the Medi-Cal program is not sufficient to overcome the presumption.

CONCLUSION 3:

Orange County's denial of the claimant's Medi-Cal application rests on its application of the presumption embodied in Section 50408(b). As it has been already concluded in Sections I and II above that $15,249.77 of his $32,672.80 community property share from the proceeds of the sale of the home have been properly disposed of, the remainder ($17,423.03) is subject to the presumption. Of that amount, $1,630.98 has not been transferred (this is one-half of amount of the funds in checking and savings accounts acknowledged in the record to be unspent as of

April 25, 1978). Thus, $15,792.05 is the outstanding balance that remains unaccounted for.

It is now concluded that that amount ($15,792.05) was not transferred for the purpose of establishing program eligibility. While the Hearing Office does not accept the expenditures submitted by the AR as valid dispositions (payments to claimant's daughter and son-in-law and niece and nephew), the objective facts present in this case are sufficient to conclude that the claimant has overcome the regulatory presumption as required by Title 22, CAC, Section 50409(b)(2). Those objective facts include consideration of the claimant's age (84), health (severe dementia), and life expectancy (short, in light of his age). Perhaps most importantly, though, are the objective facts present in this case which strongly establish that this claimant was without any possible capacity to understand the extent of his resources during the period under review. Given the previous factual finding that since January 1977 he has been unable to transact any legal business, it must be concluded that the transfers which occurred were not done by the claimant for the purpose of establishing program eligibility.

Moreover, this conclusion is further supported by the fact that because of his medical condition the claimant did not even sign the papers required for the sale of his home, much less participate in the subsequent transfers of his property.

Finally, although the transfers from the claimant's community property share of the proceeds from the sale of his home may have been detrimental to the claiment's legal interests, the fact remains that such transfers were not effected by him. Under such circumstances, the county may desire to demand an accounting via its Office of Public Guardian, but the claimant's eligibility for Medi-Cal must be acknowledged. When that is done, the $15,792.05 is disregarded, leaving him with personal property of $1,630.98 in excess of the program limit.

EXHIBIT "C"

IV

Title 22, CAC, Section 50421 provides that program eligibility may be established by spenddown of excess property when the property reserve exceeds the property limit. If the property reserve has been in excess of the property limit from the first day of the month of application through the date of application, and the property reserve is brought within the property limit by the last day of the month of application, the MFBU shall be eligible under the following conditions:

(1) All eligibility requirements except for the property limit shall be met.

(2) The property reserve is brought within the property limit in any manner except by transfer without consideration.

CONCLUSION 4:

As there was no evidence to show that the claimant was advised of the possibility of qualifying by spending down his excess personal property, Orange County must reconsider the April 1978 application.

ORDER

Orange County shall rescind its denial of the claimant's April 12, 1978 Medi-Cal application. If the claimant is then found to be otherwise eligible, the county shall allow him to meet the property limit by spending $1,630.98. In any way other than by transferring without adequate consideration and upon that event, approve his application beginning April 1978 and continuing thereafter.

Further, Orange County shall give the claimant the opportunity to choose between the following alternative remedies for any excessive shares of cost which the beneficiary has paid or obligated himself to pay since that April 1978:

1. Having his current monthly shares of cost reduced in *consecutive* months (beginning with the month immediately following the month in which this decision is implemented by a total amount equal to the total difference between the shares of cost paid or obligated by the beneficiary and the months in which the cost of covered medical services exceeded the correct share of cost; or
2. Having the county (a) issue retroactive Medi-Cal cards for each month in which the beneficiary paid or obligated himself to pay an excessive share of cost; (b) assist the claimant as needed in obtaining the appropriate refunds from the providers of covered services received during such months; and (c) notify the fiscal intermediary that the delayed billings have been authorized by a Fair Hearing Decision adopted by the Director of the Department of Health Services.

EXHIBIT "C"

CALIFORNIA DEPARTMENT
OF HEALTH SERVICES

In the Matter of the Hearing of Claimant
ENOSINSIO MANAHAN
15261 Shallow Lane
Westminister, CA 92683
Fair Hearing No. 78163110 OR
State No. 30-13-315454
District

DECISION OF THE DIRECTOR

Hearing Officer: ERNESTO J. PEREZ
County Representative: JOHN JACOBS
Authorized Representative: TIM FLYNN
Place: Santa Ana, California

Date of Hearing: July 6 & 8, 1978*
Date of County Notice: June 5, 1978
Fair Hearing Filing Date: June 8, 1978
Aid Paid Pending: N/A (Denial Action

ISSUE

The issue for resolution is whether Orange County correctly denied the claimant's April 12, 1978 application for Long-Term Care California Medical Assistance Program (Medi-Cal) benefits because of its determination that he transferred property in order to become eligible.

Based on the evidence presented at the hearing, the referee prepared a proposed decision. The Director of the

* Record left open until July 28, 1978 for the claimant to submit additional documents. Such information was received, and the record was closed on August 15, 1978. The county did not submit rebuttal evidence.

EXHIBIT "D"

State Department of Health Services, being disatisfied with the decision, herein adopts the Statement of Fact together with an amended Conclusion of Law and Order as follows:

STATEMENT OF FACT

The referee's Statement of Fact is incorporated herein by this reference.

FINDINGS OF FACT

The referee's Findings of Fact is incorporated herein by this reference.

CONCLUSIONS OF LAW

The referee's Conclusions of Laws I and II are incorporated herein by this reference.

III

Title 22, CAC, Section 50406: Transfer or conversion of property may affect eligibility. See Sections 50407 through 50411.

50408. Transfer of Property Which Does Not Result in Ineligibility.

(a) Transfer of property shall not result in ineligibility for Medi-Cal under any of the following conditions:

(1) The net market value of the property transferred, when included in the property reserve, would not result in ineligibility. The determination of value shall be made as of the time of transfer. If eligibility exists, the value of the property shall no longer be considered.

(2) Adequate consideration is received. Adequate consideration includes:

(A) A transfer which was to satisfy a legal debt.

(B) A transfer which was to reimburse someone other than a responsible relative, as specified in Section 50351, for care or benefits provided on the basis of an agreement or understanding that reimbursement would be made. The applicant or beneficiary shall provide evidence that clearly establishes that the value of the care or benefits provided was reasonably equivalent to the value of the property transferred.

(3) Foreclosure or repossession of the property was imminent at the time of transfer, and there is no evidence of collusion.

(4) The transfer was made in return for an enforceable contract for life care which does not include complete medical care. In this case, each full item of need provided under the life care contract shall be considered income in kind in accordance with Section 50509.

(b) There is a presumption that property transferred by the applicant or beneficiary more than two years preceding the date of initial application was not transferred to establish eligibility or reduce the share of cost. Such property shall not be considered in determining eligibliity, unless there is evidence that conflicts with this presumption.

50409. Transfer of Property Which Results in Ineligibility

(a) Transfer of property shall result in ineligibility for Medi-Cal if the transfer did not meet one of the conditions specified in Section 50408 or the transfer was in return for an enforceable life care contract which includes complete medical care.

(b) Transfer of property without adequate consideration shall result in ineligibility for Medi-Cal if the transfer was made to establish eligibility or to reduce the share of cost.

(1) It shall presume that property transferred without adequate consideration was for the purpose of establishing eligibility or to reduce the share of cost as limited by (2).

EXHIBIT "D"

(2) To overcome the presumption, the applicant or beneficiary has the burden of establishing by objective facts, rather than statement of subjective intent, that this presumption is not correct. The applicant or beneficiary shall provide evidence that adequate resources were available at the time of the transfer of property for support and medical care considering such things as the applicant's or beneficiary's age, health, life expectancy, and ability to understand extent of resources.

(A) The declaration of another purpose, such as to avoid probate, by itself, shall not be sufficient to overcome the presumption. A showing that the sole purpose of the transfer was for reasons other than to establish eligibility or to reduce the share of cost shall be supported by evidence such as that specified above.

(B) The establishment of the fact that the applicant or beneficiary did not have specific knowledge of the availability or benefits of the Medi-Cal program is not sufficient to overcome the presumption.

CONCLUSION 3:

Orange County's denial of the claimant's Medi-Cal application rests on its application of the presumption embodied in Section 50409(b). As it has been already concluded in Sections I and II above that $15,249.77 of his $32,672.80 community property share from the proceeds of the sale of the home have been properly disposed of, the remainder ($17,423.03) is subject to the presumption. Of that amount, $1,630.98 has not been transferred (this is one-half of amount of the funds in checking and savings accounts acknowledged in the record to be unspent as of April 25, 1978). Thus, $15,792.15 is the outstanding balance that remains unaccounted for.

It is concluded that the claimant has not overcome the presumption that the transfer of property was for the purpose of establishing eligibility. In accordance with Section

50409(b), this presumption may only be overcome by the claimant providing evidence that adequate resources were available at the time of the transfer to provide for the claimant for the remainder of his life. The transfer of property occurred some time after May 1977. The claimant had been in a nursing home since January 1977 and was in continuing need of extensive support and medical care. Evidence was not provided to show that adequate resources were available at the time of the transfer to care for the claimant for the remainder of his life. The fact that the claimant's spouse, having power of attorney and acting on behalf of the claiment, made the transfer of property does not absolve the claimant of this action. Although the claimant was incompetent, a competent person, his wife acted in his behalf.

ORDER

The claim is denied.

The foregoing is the Decision and Order of the Director, State Department of Health Services, in the above-entitled matter.

1-12-79 /s/ Elizabeth H. Lyman

(Date)

EXHIBIT "D"

UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA

No. 78-2350 MML(Sx)

ROSSYE DAWSON, individually and on behalf of all others similarly situationed, PLAINTIFF,

v.

EDWARD BEACH, ET AL., DEFENDANTS.

ANTONIA BELTRAN AND ENOSINSIO MANAHAN, individually and on behalf of all other similarly situated, INTERVENOR-PLAINTIFF.

ANSWER TO COMPLAINT IN INTERVENTION FOR DECLARATORY AND INJUNCTIVE RELIEF FILED MARCH 19, 1979

CLASS ACTION

COME NOW defendants Beverlee A. Myers, successor to Edwin W. Beach, herein erroneously sued as Edward Beach, individually and in her official capacity as Director of the California State Department of Health Services, successor to the State Department of Health, and Elisabeth Lyman, successor to Bruce Yarwood, individually and in her official capacity as Acting Chief Deputy Director of the Medical Care Services and Deputy Director of Medical Care Standards Division of the State Department of Health Services, successor to the State Department of Health, and each of them, and answer the complaint for declaratory and injunctive relief as follows:

1. Answering paragraph 1 of the complaint, defendants deny that the State of California is improperly applying

eligibility requirements which do not comport with federal law.

2. Answering paragraph 2 of the complaint, defendants deny that there is in excess of $10,000 in controversy and admit the remaining allegations of paragraph 2.

3–4. Defendants deny for lack of sufficient information or belief each and every allegation contained in paragraphs 3 and 4 of the complaint.

5. Defendants deny that Edward Beach is the former Director of Department of Health Services and affirmatively allege that Edwin Beach is the former Director of the Department of Health, predecessor to the Department of Health Services.

6. Answering paragraph 6 of the complaint, defendants deny that Bruce Yarwood is the Deputy Director of the State Department of Health Services and affirmatively allege that Elisabeth Lyman, successor to Bruce Yarwood, is the acting Chief Deputy Director of Medical Care Services and Deputy Director of Medical Care Standards Division of the Department of Health Services.

7. Answering paragraph 7 of the complaint, defendants admit that intervenors Beltran and Manahan bring this action on their own behalf and deny each and every remaining allegation contained in said paragraph 7.

8. Answering paragraph 8 of the complaint, defendants deny that state Medicaid programs are controlled solely by federal regulations. In connection therewith, defendants affirmatively allege that pursuant to the State Medicaid plan, the state enters into contracts to fulfill the particular federal options for coverage which it chooses to apply. State Medicaid programs are also controlled by state statutes and regulations.

9. Defendants admit the allegation contained in paragraph 9.

10. Answering paragraph 10 of the complaint, defendants deny that income is the only Medicaid eligibility guideline for the aged, blind, and disabled.

11. Defendants admit the allegations contained in paragraph 11 of the complaint. Defendants affirmatively allege

that Supplemental Security Income (SSI) recipients are eligible for Medicaid benefits if the State Plan so provides.

12. Defendants admit the allegations contained in paragraph 12 of the complaint.

13. Defendants deny each and every allegation contained in paragraph 13 of the complaint.

14. Answering paragraph 14 of the complaint, defendants deny the existence of a rule stating that the provision of health care will not be restricted by property holdings. Defendants admit that the quote contained in said paragraph 14 is a portion of Welfare and Institutions Code section 14015.

15. Defendants admit the allegations contained in paragraph 15 of the complaint.

16. Except as otherwise provided by 22 California Administrative Code section 50411(a), defendants admit the allegations contained in paragraph 16 of the complaint.

17. Defendants deny for lack of sufficient information and belief, each and every allegation contained in paragraph 17.

18. Defendants deny for lack of sufficient information and belief each and every allegation contained in paragraph 18. Defendants admit that Mr. and Mrs. Beltran were found eligible for Medi-Cal in May 1977. Defendants affirmatively allege that Mr. and Mrs. Beltran were found eligible under the In Home Supportive Services Program which was not then, but is now the medically needy program.

19. Defendants deny each and every allegation contained in paragraph 19 of the complaint.

20. Defendants admit the allegations contained in paragraph 20 of the complaint. Defendants affirmatively allege that a copy of only the front side of the Notice of Action is attached to the complaint as Exhibit A.

21. Except as otherwise provided by the Notice of Action defendants admit the allegations contained in paragraph 21 of the complaint.

22. Defendants deny for lack of sufficient information and belief each and every allegation contained in paragraph 22 of the complaint.

23. Defendants deny for lack of sufficient information and belief each and every allegation contained in paragraph 23 of the complaint. Defendants admit that Mr. Manahan entered the convalescent home in January 1977.

24. Defendants deny for lack of sufficient information and belief each and every allegation contained in paragraph 24. Defendants admit that on April 12, 1978, the application for Medi-Cal was made on Enosinsio Manahan's behalf by Mrs. Lucille Tom at the Orange County Department of Social Services.

25. Defendants admit the allegations contained in paragraph 25 of the complaint. Defendants affirmatively allege that only the front side of Exhibit B is attached to the complaint.

26. Defendants admit the allegations contained in paragraph 26 of the complaint.

27. Defendants admit the allegations contained in paragraph 27 of the complaint. Defendants affirmatively allege that page 12, signature page, form no. DPA 320 (8–76) is missing from Exhibit C.

28. Defendants deny each and every allegation contained in paragraph 28 of the complaint. Defendants admit that on January 12, 1979, the director of the State Department of Health Services alternated the decision of the hearing officer and a copy of the decision of the director is attached as Exhibit D to the complaint.

29. Defendants deny for lack of sufficient information and belief each and every allegation contained in paragraph 29.

30–31. Defendants deny each and every allegation contained in paragraphs 30 and 31.

FIRST CAUSE OF ACTION

32–33. Defendants deny each and every allegation contained in paragraphs 32 and 33. Defendants affirmatively

allege that California is providing Medi-Cal benefits automatically to all persons receiving SSI benefits and that the SSI program does not predicate eligibility on a transfer of assets for adequate consideration prior to application if the transfer is bona fide and irrevocable.

34–35. Defendants admit the allegations contained in paragraphs 34 and 35. Defendants affirmatively allege that 42 Code of Federal Procedure section 448.3(c)(1)(iv) and its successor regulation provide an alternative by which the states may impose a more stringent criteria.

36. Defendants deny each and every allegation contained in paragraph 36 of the complaint.

SECOND CAUSE OF ACTION

37. Defendants deny each and every allegation contained in paragraph 37 of the complaint.

THIRD CAUSE OF ACTION

38. Defendants deny each and every allegation contained in paragraph 38 of the complaint.

FOURTH CAUSE OF ACTION

39. Defendants deny each and every allegation contained in paragraph 39 of the complaint.

FIFTH CAUSE OF ACTION

40. Defendants deny each and every allegation contained in paragraph 40 of the complaint.

FIRST AFFIRMATIVE DEFENSE

1. The Court should dismiss the complaint for lack of jurisdiction over the subject matter and for failure to state a claim upon which relief could be granted on the ground that the plaintiffs have failed to exhaust their available administrative remedies provided by California Government Code section 11426.

SECOND AFFIRMATIVE DEFENSE

2. The Court should dismiss the complaint for lack of jurisdiction over the subject matter and for failure to state a claim upon which relief can be granted, on the ground that the exclusive remedy for judicial review of adjudicatory administrative action is to file a petition for writ of mandate in the state court pursuant to California Code of Civil Procedure section 1094.5.

THIRD AFFIRMATIVE DEFENSE

3. The Court should dismiss the complaint for lack of jurisdiction over the subject matter and for failure to state a claim upon which relief could be granted on the ground that plaintiff Antonia Beltran has failed to exhaust her available administrative remedy provided by Welfare and Institutions Code sections 10950–10963, 14001; Title 22 California Administrative Code sections 50951–50955.

FOURTH AFFIRMATIVE DEFENSE

4. The Court should dismiss the complaint for failure to state a claim upon which relief could be granted on the ground that one or more of the plaintiffs lack the mental and/or physical capacity to sue. On or about October 12, 1978, defendants are informed and believe that plaintiff Rossye Dawson died.

FIFTH AFFIRMATIVE DEFENSE

5. The Court should dismiss the complaint for lack of jurisdiction over the subject matter because the amount in controversy is less than ten thousand dollars, exclusive of interests and costs, in that if any one or more of the plaintiffs have any claim against defendants, such claims constitute separate claims of the particular plaintiffs so damaged, none of which separately equals or exceeds ten thousand dollars, exclusive of interests and costs, and such claims, cannot be aggregated for purposes of the amount in controversy requirement.

SIXTH AFFIRMATIVE DEFENSE

6. The complaint fails to state a claim against defendants upon which relief can be granted.

WHEREFORE, defendants deny that the plantiffs are entitled to the relief prayed for in the complaint, or any relief whatsoever against defendants, and defendants respectfully pray that the complaint be dismissed with costs and disbursements to the defendants.

DATED: March 19, 1979.

GEORGE DEUKMEJIAN, Attorney General
ANNE S. PRESSMAN,
DONALD A. ROBINSON,
RICHARD J. MAGASIN, Deputy Attorneys General

By _____
DONALD A. ROBINSON

By _____
RICHARD J. AGASIN
Attorneys for Defendants

UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA

No. CV-78-2350-MML

ROSSYE DAWSON, individually and on behalf of all others similarly situated, PLAINTIFF,

v.

EDWARD BEACH, ET AL., DEFENDANTS.

ANTONIA BELTRAN AND ENOSINSIO MANAHAN, individually and on behalf of all others similarly situated, INTERVENOR-PLAINTIFF,

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ORDER GRANTING PLAINTIFFS' MOTION FOR CERTIFICATION OF THE CLASS FILED MAY 10, 1979

The Court having considered plaintiffs' motion for an order certifying this case as a class action pursuant to Rule 23(c)(1) of the Federal Rules of Civil Procedure, and the Court having considered memoranda and arguments of the parties, it is determined that this action meets the requirements of Rule 23(a) in that:

(1) Joinder of all members of the class would be impracticable since their number, though unknown, is great (the defendants having stipulated to numerosity); they are dispersed throughout the State of California and by definition they are aged, blind and disabled and, therefore, would be incapable of participating in this action as individual plaintiffs;

(2) There are questions of law and fact common to each member of the class. The common question of fact is that each has been denied Medi-Cal benefits because of the de-

fendants' application of a transfer of assets rule to them. The common question of law is the propriety of the application of the transfer of assets rule;

(3) The claims of the plaintiffs are typical of the claims of each class member, as each of the named plaintiffs has been denied Medi-Cal as a result of the application of the transfer of assets rule;

(4) Plaintiffs will fairly and adequately protect the interests of the class. They are represented by able counsel, who are experienced in class action litigation.

Furthermore, this action also meets the requirements of Rule 23(b)(2) in that the defendants have acted on grounds generally applicable to the class, and final injunctive and declaratory relief with respect to the class as a whole is appropriate.

IT IS THEREFORE ORDERED that this action shall be maintained as a class action, the class to consist of all aged, blind and disabled individuals who, as of June 19, 1978, have been or are denied Medi-Cal benefits because of an alleged transfer of assets for inadequate consideration pursuant to Welf. & Inst. C. § 14015 and 22 Cal.Adm. Code § 50409.

Dated: May 9, 1979

/s/ _____

MALCOLM M. LUCAS
United States District Judge

UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA

No. CV-78-2350-MML

ROSSYE DAWSON, individually and on behalf of all others similarly situated, PLAINTIFF

v.

EDWARD BEACH, ET AL., DEFENDANTS

ANTONIA BELTRAN AND ENOSINSIO MANAHAN, individually and on behalf of all others similarly situated, INTERVENOR-PLAINTIFF,

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FINDINGS OF FACT AND CONCLUSIONS OF LAW FILED MAY 10, 1979

This cause came on for hearing on defendants' Motion for Summary Judgment and plaintiffs' Cross-Motion for Summary Judgment, and the Court, having considered the memoranda of points and authorities filed by the parties in support of such motions and the documents and exhibits thereto, and the stipulation of the parties, and having heard oral argument by the parties in support of such motions, finds the facts and states the conclusion of law as follows:

FINDINGS OF FACT

1. With respect to Rossye Dawson.

a. On February 18, 1977, an application for Medi-Cal was filed on behalf of Rossye Dawson;

b. The County of Riverside Department of Public Social Services approved the application pending a property verification;

c. On May 17, 1977, the County of Riverside Department of Public Social Services sent a Notice of Action letter to Rossye Dawson determining that she was no longer eligible for Medical-Cal because she had transferred property without adequate consideration in violation of Title 22, California Administrative Code section 50409;

d. Rossye Dawson filed a request for a fair hearing, which was held on September 14, 1977;

e. The hearing officer found that the transfer of property for inadequate consideration was in May 1977, that Rossye Dawson had failed to overcome the presumption that the transfer was made for the purpose of qualifying for Medi-Cal, and that therefore her claim for Medi-Cal benefits should be denied;

f. The proposed decision of the hearing officer was adopted by the Director of the State Department of Health on February 15, 1978;

g. Rossye Dawson has never sought judicial review of the director's decision by filing a petition for writ of mandate pursuant to section 1094.5 of the California Code of Civil Procedure; and

h. On or about October 30, 1978, counsel for Rossye Dawson filed a "Certificate of Counsel re Death of Plaintiff." No substitution for the deceased plaintiff has been made.

2. With respect to intervenor Enosinsio Manahan:

a. On April 12, 1978, an application for Medi-Cal was filed on behalf of Mr. Manahan;

b. The Orange County Department of Social Services denied his application on the ground that he had transferred property in order to be eligible for Medi-Cal in violation of, *inter alia*, Title 22 California Administrative Code section 50409;

c. A fair hearing was requested and held on July 6 and 7, 1978 on the county's denial of Medi-Cal;

d. The hearing officer found that Mr. Manahan had overcome the presumption that the transfer of property was for the purpose of qualifying for Medi-Cal. The hear-

ing officer recommended that he be eligible for Medi-Cal once he met the Medi-Cal property limit spend-down.

e. On January 12, 1978, the Director of the State Department of Health Services reversed the proposed decision of the hearing officer. The director found that Mr. Manahan had not overcome the presumption; and

f. He has not sought judicial review of the director's decision by filing a petition for writ of mandate in the state court pursuant to California Code of Civil Procedure section 1094.5.

3. With respect to intervenor Antonia Beltran:

a. On October 27, 1978, she re-applied for Medical benefits;

b. The Notice of Action dated January 8, 1979 indicated that the denial of Medi-Cal eligibility was based on a transfer of property in 1977.

c. She did not request a fair hearing from the determination of the county, and no fair hearing was held.

4. Except for the application of the transfer of assets rule to these three individuals, they would be eligible for Medi-Cal coverage under the state's medically needy program.

5. Defendant Beverlee A. Myers, successor to Edwin W. Beach, is the Director of the California State Department of Health Services, successor to the State Department of Health.

6. Defendant Elisabeth Lyman, successor to Bruce Yarwood, is the Acting Chief Deputy Director of the Medical Care Services and Medical Care Standards Division of the State Department of Health Services.

7. To the extent that any of the following conclusions of law are deemed findings of fact, the same are incorporated herein by reference.

CONCLUSIONS OF LAW

1. The Court has jurisdiction over this case pursuant to 28 U.S.C. § 1343(3), (4), as this is an action authorized by

42 U.S.C. § 1383 to redress the deprivation of rights under color of state law. The Court has pendent jurisdiction over any claims not specifically authorized pursuant to 42 U.S.C. § 1983. Jurisdiction is also conferred by 28 U.S.C. § 1331, as there is more than $10,000.00 in controversy. This case has been certified as a class action.

2. Rossye Dawson lacks capacity to sue as she is deceased and no substitution has been made for her pursuant to Federal Rules of Civil Procedure section 25(a)(1).

3. The federal Medicaid Program, Title XIX of the Social Security Act, 42 U.S.C. § 1396 *et seq.*, is a system of cooperative federalism in which the states and other jurisdictions have the option to participate, and to receive partial reimbursement for services provided. If they decide to participate, the states are required to operate their Medicaid Program within the contours of the federal statute and regulations, and to submit a state plan to the Secretary of the Department of Health, Education, and Welfare that comports with controlling federal laws. In order to be eligible for reimbursement, the states which decide to participate must comply with the mandatory requirements established by the Social Security Act as interpreted and implemented by HEW. *Townsend* v. *Swank*, 404 U.S. 282, 286 (1971); *King* v. *Smith*, 392 U.S. 309, 333 (1968); *County of Alameda* v. *Carleson*, 5 Cal.3d 730, 739 (1971); *Wong* v. *Brian*, CCH Medicare & Medicaid Guide, [1974] Transfer Binder, ¶ 26, 605 (Cal.Ct. App. 1972).

4. Once a state decides to participate, it must provide Medicaid benefits to the "categorically needy", who are individuals meeting both the categorical requirements of being aged, blind, or disabled, and also the financial eligibility requirements. 42 U.S.C. § 1396a(a)(10)(A); 42 C.F.R. § 435.120; see *Friedman* v. *Berger*, 547 F.2d 724, 726 (2d Cir. 1976), *cert. denied* 430 U.S. 984 (1977); *Wong* v. *Brian*, *supra*, ¶ 26, 605 at 9013.

5. In addition, states have the option of providing Medicaid assistance to the so-called "medically needy" who are individuals meeting the categorical requirements of being aged, blind or disabled, but who have incomes or

resources above the financial requirements. 42 U.S.C. § 1396a(a)(10)(C); 42 C.F.R. § 435.300 *et seq.*, see *Friedman* v. *Berger, supra; Wong* v. *Brian, supra.*

6. California has opted to participate in the Medicaid Program, and has further opted to provide assistance to the medically needy. 22 Cal.Adm. Code § 60249(a)(1); *Wong* v. *Brian, supra.*

7. The general rule is that recipients of Supplemental Security Income ("SSI"), who are aged, blind, or disabled individuals receiving federal cash benefits, are categorically needy and are therefore automatically eligible for Medicaid. 42 U.S.C. § 1396a(a)(10)(A). California, as well as other states, has been given the option by Congress of using a different eligibility test for the categorically needy than that they be recipients of SSI. Under this test, a state can use more restrictive financial eligibility conditions than those set out in the SSI program, but no more restrictive than those in effect in the state on January 1, 1972. 42 U.S.C. § 1396a(f); 42 C.F.R. § 431.121; see *Hayes* v. *Stanton*, 512 F.2d 133, 137-138 (7th Cir. 1975); *West* v. *Cole*, 390 F.Supp. 91, 95-96 (N.D. Miss. 1975); *Gray Panthers* v. *Secretary, Department of Health, Education and Welfare*, 461 F.Supp. 319, 321 (D.D.C. 1978).

8. In its Medicaid Program, known in this state as Medi-Cal, California has not selected this option, and therefore must provide, and does provide, automatic categorical assistance to all recipients of SSI. Cal. Adm. Code § 50227.

9. The federal Medicaid statute requires those states which provide medically needy benefits to include as eligible "all individuals who would, except for income and resources, be eligible to have paid with respect to them Supplemental Security Income benefits . . . ." 42 U.S.C. § 1396a (a)(10)(C)(i).

10. A state may not impose conditions of eligibility on the medically needy that are more restrictive than those imposed on the categorically needy, that is, recipients of SSI. 42 C.F.R. § 435.401(c). Of course, a state may impose

collateral restrictions on the medically needy that are not imposed on the categorically needy. 42 U.S.C. § 1396a (a)(17)(A); 45 CFR § 233.10(a)(1)(ii)(B).

11. Cal.Welf. & Inst. Code § 14015 and 22 Cal.Adm. Code § 50409 are designed to eliminate fraudulent practices affecting eligiblity for benefits. The federal statute is concerned with substantive eligibilty requirements only, and does not place any specific restrictions on the state's right to police fraud. Consequently, the transfer of assets rule is a procedural regulation which is not prohibited by 42 USC § 1396a(a)(10)(C)(i).

12. Cal.Welf. & Inst. Code § 14015 and 22 Cal.Adm. Code § 50409 do not violate 42 U.S.C. § 1396a(a)(17)(B) or 42 CFR § 435.845. The purpose of these state law provisions is to deter transfers of assets solely for the purpose of qualification. To the extent an asset is transferred for the purpose of qualifying for benefits, the asset should be treated as being available for the applicant's use.

13. Cal.Welf. & Inst. Code § 14015 and 22 Cal.Adm. Code § 50409 are not in conflict with any federal law or regulation governing the Medicaid/Medi-Cal program. They do not violate the Supremacy Clause of the United States Constitution.

14. Cal. Welf. & Inst. Code § 14015 and 22 Cal.Adm. Code § 50409 do not establish an irrebutable presumption that a transfer of assets was made with the intent of gaining eligibility and so do not violate the due process clause of the Fourteenth Amendment to the United States Constitution.

15. A rational distinction between SSI recipients and the medically needy is made in Cal. Welf. & Inst. Code § 14015 and 22 Cal. Adm. Code § 50409. The state has an interest in assuring that medical assistance benefits are dispersed only to those who are truly in need. Those receiving SSI by definition are in financial need. It is rational for the state to scrutinize transfers of assets by the medically needy to assure that financial eligibility is not improperly manufactured. The Court therefore holds that the equal protection clause of the Fourteenth Amendment

has not been violated by Cal.Welf. & Inst. Code § 14015 and 22 Cal. Adm. Code § 50409.

16. To the extent that any of the foregoing findings of fact are deemed conclusions of law, the same are incorporated herein by reference.

17. The plaintiff's motion for summary judgment is denied, and the defendants' motion for summary judgment is granted. Judgement shall be entered accordingly.

Dated: May 10, 1979

/s/ _____

MALCOLM M. LUCAS
United States District Judge

GEORGE DEUKMEJIAN, Attorney General
ANNE S. PRESSMAN,
DONALD A. ROBINSON,
RICHARD J. MAGASIN, Deputy Attorneys General
3580 Wilshire Boulevard, Suite 800
Los Angeles, California 90010
Telephones: (213) 736-2214, 736-2606

Attorneys for Defendants

UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA

NO. 78-2350 MML(Sx)

ROSSYE DAWSON, individually and on behalf of all others similarly situated, PLAINTIFF,

v.

EDWARD BEACH, ET AL., DEFENDANTS.

ANTONIA BELTRAN AND ENOSINSIO MANAHAN, Individually and on behalf of all other similarly situated, INTERVENOR-PLAINTIFF,

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SUMMARY JUDGMENT
ENTERED MAY 10, 1979

This cause came on to be heard on motion of the defendants for summary judgment and on cross-motion of the plaintiffs and intervenor plaintiffs for summary judgment, pursuant to Rule 56 of the Federal Rules of Civil Procedure, and the court having considered all papers, and the court having heard the argument of counsel, and due deliberation having been had thereon, it is

ORDERED, that plaintiffs' cross-motion for summary judgment be the same hereby is denied, and it is further

ORDERED, that defendants' motion for summary judgment be and the same hereby is granted, and it is further

ORDERED, ADJUDGED AND DECREED that the action be dismissed on its merits, and that each side bear own costs of suit.

DATED: 5/19/79.

/s/ _____

MALCOLM M. LUCAS
United States District Judge

IN THE UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

No. 79-3246

ROSSYE DAWSON, individually and on behalf of all others similarly situated, PLAINTIFF-APPELLANT,

v.

BEVERLEE A. MYERS,* ET AL., DEFENDANTS-APPELLEES.

On Appeal from the United States District Court
for the Central District of California
The Honorable Malcolm M. Lucas, Presiding

OPINION—FILED MAY 14, 1980
D.C. No. C 78-2350 MML

Before: WRIGHT and ANDERSON, *Circuit Judges*, and SOLOMON, ** *District Judge*.

J. BLAINE ANDERSON, *Circuit Judge:*

This is a class action challenging the State of California's transfer of assets rule which was relied upon to deny Medi-Cal benefits to members of the class. In short, this rule denies Medi-Cal benefits to any individual who has transferred assets so as to qualify under the financial eli-

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*Beverlee A. Myers, the Director of the California State Department of Health Services, is the successor to Edwin W. Beach, the originally named defendant. Since Myers succeeded Beach prior to when this appeal was taken, we make the substitution under Fed. R. Civ. P. 25(d)(1) rather than Fed. R. App. P. 43(c)(1).

**The Honorable Gus J. Solomon, Senior United States District Judge for the District of Oregon, sitting by designation.

gibility requirements for Medi-Cal. The class members argue that the transfer rule conflicts with the federal Medicaid statutes and regulations, and they also challenge the rule's constitutionality based on due process and equal protection grounds. The court below rejected all of these arguments and upheld the transfer rule. We believe that the district court reached the correct result and affirm.

I. Background

A. *Medicaid*

Title XIX of the Social Security Act established the Medicaid program. 42 U.S.C. § 1396 *et seq*. This cooperative federal-state program is designed to provide medical assistance to certain classes of individuals who are in need of such assistance. Although states are not required to participate, if they choose to do so they must develop a plan which conforms to the federal guidelines. 42 U.S.C. § 1396(b). Despite the extensive federal standards (42 U.S.C. § 1396a), the individual states are given wide discretion in the administration of their local programs. *Norman v. St. Clair*, 610 F.2d 1228, 1230 (5th Cir. 1980). After a state's plan is approved by the Secretary of Health, Education and Welfare, the state then receives reimbursement for a portion of the funds which are expended. 42 U.S.C. § 1396.

A state which has chosen to adopt a Medicaid program has the option of deciding whether it should provide benefits to only one or to both of the statutorily-defined groups of needy persons. States participating in the program *must* provide assistance to the group which is referred to as the *categorically needy*.[1] 42 U.S.C. § 1396a(10)(A). Generally, in order to be considered *categorically needy*,

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[1] The regulations define this group as follows:

> Categorically needy" means aged, blind or disabled individuals or families and children who are otherwise eligible for medicaid and who meet the financial eligibility requirements for AFDC, SSI, or an optional State supplement;"

42 C.F.R. § 435.4.

an individual must be receiving financial assistance, or be financially eligible for such assistance, under Title IV–A of the Social Security Act (Aid to Families with Dependent Children, referred to as AFDC) or Title XVI of the Social Security Act (Supplemental Security Income for the Aged, Blind, and Disabled, referred to as SSI).[2]

When they establish their Medicaid program, the states have the option of also providing benefits to the group which is referred to as the *medically needy*. This group covers individuals who would qualify for AFDC or SSI except that they have sufficient income and resources to cover the essentials aside from their medical costs.[3] The *medically needy* begin receiving assistance after they have incurred medical expenses which reduce their income (and assets) below a prescribed level. Thus, the chief distinction between the two groups is that the *categorically needy* have lower incomes and less resources than the *medically needy*.

B. *Medi-Cal*

California, through its Medi-Cal program, has voluntarily chosen to participate in the Medicaid program. In addition, California voluntarily chose to cover the *medically needy* as well as the *categorically needy*. California has adopted a comprehensive statutory and regulatory scheme to implement its Medi-Cal program.

As part of its plan, the California legislature adopted what is called a transfer of assets rule. Cal. (Welf. & Inst.)

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[2] States have the option of using more restrictive criteria than those used under the AFDC or SSI programs. California has not chosen this option and so this opinion does not deal with those provisions of the Medicaid Act which would then come into play.

[3] The regulations define this group as follows:

> "Medically needy" means aged, blind, or disabled individuals or families and children who are otherwise eligible for medicaid and whose income and resources are above the limits set under the medicaid State plan;"

43 C.F.R. § 435.4.

Code § 14015.[4] Basically, this prevents persons from qualifying as *medically needy* if they have transferred assets for less than fair consideration within two years prior to their application for assistance. The transfer rule only applies to applicants in the *medically needy* group; it has no application at all to the *categorically needy*.

California has promulgated regulations which, among other things, establish eligibility requirements for the *medically needy* and implement the transfer rule.[5] Under

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[4] The statutory part of the transfer rule provides as follows:

> "The providing of health care under this chapter shall not impose any limitation or restriction upon the person's right to sell, exchange or change the form of property holdings nor shall the care provided constitute any encumbrance on the holdings. However, any transfer of the holdings by gift or, knowingly, without adequate and reasonable consideration, shall be presumed to constitute a gift of property with intent to qualify for assistance and such act shall disqualify the owner for further aid for a period determined under standards established by the director, and in no event for less than half of the period that the capital value of the transferred property would have supplied the person's maintenance needs based on his circumstances at the time of his transfer plus the cost of any needed medical care."

Cal. (Welf. & Inst.) Code § 14015.

[5] The transfer rule is implemented, for the most part, through 22 Cal. Admin. Code §§ 50408, 50409. The first section (§ 50408) states the general conditions for when the transfer of property will not result in ineligibility. The rule and the procedure for overcoming the presumption are then stated in § 50409:

> "(a) Transfer of property shall result in ineligibility for Medi-Cal if the transfer did not meet at least one of the conditions specified in Section 50408 or the transfer was in return for an enforceable life care contract which includes complete medical care.
>
> "(b) Transfer of property without adequate consideration shall result in ineligibility for Medi-Cal if the transfer was made to establish eligibility or to reduce the share of cost.
>
> "(1) It shall be presumed that property transferred without adequate consideration was for the purpose of establishing eligibility or to reduce the share of cost as limited by (2).
>
> "(2) To overcome the presumption, the applicant or beneficiary has the burden of establishing by objective facts,

these regulations, an individual is eligible as *medically needy* only if his or her assets are valued at $1500 or less. 22 Cal. Admin. Code § 50420. An individual's home, income-producing real property, and certain other assets are not counted toward the $1500 limitation. 22 Cal. Admin. Code §§ 50418, 50425–50489. Although this property is exempt insofar as determining eligibility, it remains potentially subject to California's recovery procedures. That is, after the individual dies, California is entitled to recover the cost of medical assistance it provided to the individual from the assets (including both exempt and nonexempt property) which are left in the individual's estate.

Under the regulations which implement the transfer rule, any transfer of assets (including exempt property) for less than adequate consideration creates a rebuttable presumption that the transfer was made for the purpose of establishing eligibility. Unless the applicant rebuts the presumption, the state can deny benefits on this basis.

C. *Facts*

Dawson, who originally filed this action, has died. Two other individuals, Beltran and Manahan, intervened. Bel-

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rather than statement of subjective intent, that this presumption is not correct. The applicant or beneficiary shall provide evidence that adequate resources were available at the time of the transfer of property for support and medical care considering such things as the applicant's or beneficiary's age, health, life expectancy, and ability to understand extent of resources.

"(A) The declaration of another purpose, such as to avoid probate, by itself, shall not be sufficient to overcome the presumption. A showing that the sole purpose of the transfer was for reasons other than to establish eligibility or to reduce the share of cost shall be supported by evidence such as that specified above.

"(B) The establishment of the fact that the applicant or beneficiary did not have specific knowledge of the availability or benefits of the Medi-Cal program is not sufficient to overcome the presumption."

tran, who is 87, lives in an extended care facility. Manahan, who is 85, lives in a convalescent home. Both Beltran and Manahan were *medically needy* and otherwise qualified to receive Medi-Cal benefits. However, both were denied benefits based on the fact that they had transferred assets for less than adequate consideration prior to applying for Medi-Cal. Neither was able to overcome the presumption of ineligibility resulting from these transfers.

In their complaint, Beltran and Manahan (referred to as appellants), on behalf of themselves and others similarly situated, sought declaratory and injunctive relief invalidating and enjoining the California transfer rule. In addition, the appellants sought reimbursement for those amounts which they had been forced to pay because of the state's transfer rule. The district court certified a class consisting of all those who had been denied Medi-Cal benefits based on California's transfer rule.

On May 10, 1979, the district court granted California's motion for summary judgment and denied the cross motion filed by the appellants. The court entered findings of fact and conclusions of law which held that the state's transfer rule did not conflict with the federal statutory and regulatory framework, nor did it amount to a denial of due process or equal protection. The appellants then brought this appeal.[6]

II. Discussion

The appellants make five distinct arguments against California's transfer rule. They claim that it creates an ir-

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[6] The district court concluded that it has jurisdiction under 28 U.S.C. § 1343(3) & (4) (civil rights jurisdiction) and under 28 U.S.C. §1331 (federal question jurisdiction). It is unclear whether jurisdiction was properly invoked under 28 U.S. § 1343. *See Chapman v. Houston Welfare Rights Orig.*, 441 U.S. 600, 99 S.Ct. 1905, 60 L.Ed. 2d 508 (1979); *Doe v. Klein*, 559 F.2d 338 (9th Cir. 1979). Nevertheless, the amount in controversy exceeds $10,000 and so the district court did clearly have federal question jurisdiction (28 U.S.C. § 1331). *Brown v. Stanton*, F.2d No. 79-1459, slip op. 2 n.1 (7th Cir. 1980); *see Chapman, supra*, 60 L.Ed.2d at 515. Since the appellants filed a timely notice of appeal from the final judgement, this court has jurisdiction to consider the appeal under 28 U.S.C. § 1291.

rebuttable presumption in violation of the due process clause. Since the rule only applies to the *medically needy*, they contend that it also violates the equal protection clause. Furthermore, the appellants claim that the transfer rule conflicts with two different sections of the federal statutes (42 U.S.C. § 1346a(a)(10)(C), 1396a(a)(17)(B), as well as one section of the federal regulations (42 C.F.R. § 435.401). We address the challenges based on the federal statutes and regulations first because if the appellants' arguments are correct, we would not need to reach the constitutional issues. *Dandridge v. Williams*, 397 U.S. 471, 475–476, 25 L.Ed.2d 491, 90 S.Ct. 1153 (1970). Moreover, in addressing appellants' arguments, the cardinal principle of statutory construction must be kept in mind, that is, statutes should be construed to avoid constitutional questions. *See Swain v. Pressley*, 430 U.S. 372, 378 n.11, 97 S.Ct. 1224, 51 L.Ed.2d 411 (1977)

A. *42 U.S.C. § 1396a(a)(10)(C)*

Appellants' primary argument is that the California transfer rule conflicts with 42 U.S.C. § 1396a (a)(10)(C), which requires states providing benefits to the *medically needy* to cover "all individuals who would, except for income and resources" be eligible for SSI (and therefore come under the *categorically needy* classification), "and who have insufficient (as determined in accordance with comparable standards) income and resources to meet the costs of necessary medical and remedial care and services."[7] The appellants attribute the following meaning to

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[7] This statute provides, in part, as follows:

"A state plan for medical assistance must —provide—

"(C) if medical assistance is included for any group of individuals who are not described in clause (A) and who do not meet the income and resources requirements of the appropriate State plan, or the supplemental security income program under subchapter XVI of this chapter, as the case may be, as determined in accordance with standards prescribed by the Secretary—

"(i) *for making medical assistance available to all individuals who would, except for income and resources, be eligible for aid or assistance under any such State plan or to*

§ 1396(a)(10)(C): "except for the definitional distinction that the medically needy may have higher income and resource levels, the states must use the same rules for the medically needy as for the categorically needy."

Under the Social Security Act, an SSI applicant whose assets exceed the eligibility levels may dispose of the excess assets in order to become eligible for SSI payments. 42 U.S.C. § 1382b(b). This has been administratively interpreted to permit the transfer of the excess assets for less than adequate consideration or as a gift. Social Security Claims Manual § 12507(a). According to the appellants, since transfer rules cannot be applied to SSI applicants (i.e., the *categorically needy*), they therefore cannot be applied to the *medically needy*.

The court below rejected the appellants' reasoning and concluded that the California transfer rule did not conflict with § 1396a(a)(10)(C). The court agreed with the appellants that California could not employ any substantive eligibility requirements on the *medically needy* which were more restrictive than those used for the *categorically needy*. Nevertheless, the court characterized the transfer rule as a collateral or procedural eligibility requirement which was permissible under the Social Security Act. While we agree with the district court that the California transfer rule does not conflict with § 1396a(a)(10)(C), we do not accept the semantic distinction which was relied upon.

We believe that the California transfer rule is properly characterized as a substantive eligiblity requirement. It

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have paid with respect to them supplemental security income benefits under subchapter XVI of this chapter, and who have insufficient (as determined in accordance with comparable standards) income and resources to meet the costs and services, and

"(ii) that the medical assistance made available to all individuals not described in clause (A) shall be equal in amount, duration, and scope;

***(emphasis added to show that portion of the statute which the appellants rely upon)

42 U.S.C. § 1396a(a) (10).

directly applies to the state's determination of whether an applicant's assets exceed the eligibility requirements.

In considering the appellant's argument, we must first turn to the language of the statute itself. Obviously, the face of this statute says nothing about prohibiting transfer rules such as California's.[8]

The portion of the statute with which we are concerned may be divided into two parts. The first part provides that the medically needy group includes all who would, except for their income and resources, be eligible for SSI. The second part provides that the medically needy group includes all who have insufficient income and resources, as determined under comparable standards, to pay for their medical care.

The first part specifically excepts income and resources when it equates SSI eligibility to the *medically needy* eligibility requirements. And so, while this provision does extend all of the SSI eligibility requirements to the *medically needy*, it does not do so for those which deal with the applicant's income and resources. Were this not the case, then there would be no distinction between the two groups. There can be no question but that the California transfer rule is an eligibility requirement which pertains to the applicant's income and resources. It therefore clearly comes within the exception to the first clause of the statute.

The second part may be read as requiring that the evaluation of the applicant's income and resources be de-

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[8] At one point, appellants suggest that states can only use requirements which are explicitly authorized by the federal statute. We were unable to find any provision of the statute which said this. In the absence of some expression by Congress to the contrary, we decline to read such a prohibition into a statute which is, after all, establishing a *cooperative* federal state program. *See, New York Department of Social Services v. Dublino*, 413 U.S. 405, 93 S.Ct. 2507, 37 L.Ed.2d 688 (1973) ("It will not be presumed that a federal statute was intended to supersede the exercise of the power of the state unless there is a clear manifestation of an intention to do so." 413 U.S. at 413, *quoting Schwartz v. Texas*, 344 U.S. 199, 202–203, 73 S.Ct. 232, 97 L.Ed. 231 (1952)).

termined by using comparable standards. Since an SSI applicant is apparently specifically allowed to transfer assets in the manner in which is prohibited by the California transfer rule, we are faced with an inconsistent standard. Nevertheless, this does not make the California rule necessarily in conflict with this part of the statute. After all, the statute only requires the standards to be comparable, not identical. Comparable only means that there must be enough similar characteristics or qualities to make comparison appropriate. Webster's Third New International Dictionary, G.& C. Merriam Co. (1976). The other standards which are used for determining financial eligibility are similar enough to invite comparison. We therefore cannot say that the standards used by California to determine eligibility into the *medically needy* group (including the transfer rule) are not comparable to those which are used under the SSI program.

In support of their argument, the appellants claim that HEW, the agency charged with administering the Medicaid program, has interpreted § 1396a(a)(10)(C) in the same manner as they would have this court. Apparently, three different HEW Regional Medical Directors have written letters stating that state transfer rules are inconsistent with § 1396a(a)(10)(C) because they impose more restrictive eligibility requirements on the *medically needy* than on SSI applicants. *See Fabula* v. *Buck*, 598 F.2d 869, 873 (4th Cir. 1979). Although this court generally defers to an administrative agency's interpretation of the law which it is charged with administering, we are by no means bound by the agency's interpretation. *Pacific Coast Medical Enterprises* v. *Harris*, F.2d, slip op. 2516, 2525–2526 (9th Cir., March 28, 1980); *Baker* v. *United States*, 613 F.2d 224, 226–227 (9th Cir. 1980).

In the present case, we not only refuse to follow the letter interpretations, but we also refuse to attach any weight to them. Initially, we are convinced that our interpretation of § 1396a(a)(10)(C) is correct, that is, the California transfer rule does not conflict with the statute. This court's "deference does not extend to agencies' construction which conflict with statutory directives." *Pacific*

Coast, *supra*, slip op. at 2526. While regional administrators may be writing letters disapproving of state transfer rules, HEW as a whole has approved California's Medi-Cal program (and the transfer rule). By this approval, and by not taking any action against California because of the transfer rule, HEW "has in effect expressed its view that the plan is in compliance with applicable statutory and regulatory requirements." *Michael Reese Physicians & Surgeons, S.C.* v. *Quern*, 606 F.2d 732, 735–736 (7th Cir. 1979). Based on the preceding, not only do we believe that the letter rulings should not be followed, but we also believe that HEW's general acceptance of California's Medi-Cal program supports our interpretation.

As further support for their argument under § 1396a (a)(10)(C), the appellants rely upon the subsequent legilsative history of the Medicaid program. In 1978, as part of the Medicare-Medicaid Administrative and Reimbursement Reform Act, the Senate Finance Committee proposed an amendment to the Medicaid statute which would have specifically required states to adopt transfer rules such as California's. S. Rep. No. 95–1111, 95th Cong., 2d Sess., 24–25 (1978). Apparently, relying upon what we have already concluded was an erroneous agency interpretation of § 1396a(a)(10)(C), the Senate Committee said that the states were not able to adopt transfer rules under present law. *Id.* We recognize that the pronouncements of legislative committees as to the meaning of previously enacted statutes are often afforded considerable deference. *Sioux Tribe of Indians* v. *United States*, 316 U.S. 317, 329–330, 62 S.Ct. 1095, 86 L.Ed. 1501 (1942). Nevertheless, courts are not bound by such pronouncements and it has been suggested that subsequently expressed Congressional views should not be relied upon at all. *Mathews* v. *Weber*, 423 U.S. 261, 272 n.7, 96 S.Ct. 549, 46 L.Ed.2d 483 (1976). Since the Senate Committee was apparently relying upon the erroneous administrative interpretation, and because we remain convinced that our interpretation of § 1396a(a)(10)(C) is correct, we choose

not to accord any deference to the latter legislative pronouncements.

We conclude that California's transfer rule does not conflict with 42 U.S.C. § 1396a(a)(10)(C).

B. *42 U.S.C. § 1396a(a)(17)(B)*

The appellants argue that the California transfer rule violates 42 U.S.C. § 1396a(a)(17)(B).[9] This section requires states to only consider the income and resources which are "available" to the applicant in determining eligibility. The California transfer rule assumes the availability of assets, which, according to the appellants, are no longer available to the applicant.

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[9] This statute provides in part as follows:

"A state plan for medical assistance must—

"include reasonable standards (which shall be comparable for all groups and may, in accordance with standards prescribed by the Secretary, differ with respect to income levels, but only in the case of applicants or recipients of assistance under the plan who are not receiving aid or assistance under any plan of the State approved under subchapter I, X, XIV, or XVI, or part A of subchapter IV of this chapter, and with respect to whom supplemental security income benefits are not being paid under subchapter XVI of this chapter based on the variations between shelter costs in urban areas and in rural areas) for determining eligibility for and the extent of medical assistance under the plan which (A) are consistent with the objectives of this subchapter, (B) *provide for taking into account only such income and resources as are, as determined in accordance with standards prescribed by the Secretary, available to the applicant or recipient and* (in the case of any applicant or recipient who would, except for income and resources, be eligible for aid or assistance in the form of money payments under any plan of the State approved under subchapter I, X, XIV, or XVI, or part A of subchapter IV, or who have paid with respect to him supplemental security income benefits under subchapter XVI of this chapter as would not be disregarded (or set aside for future needs) *in determining his eligibility for such aid, assistance, or benefits...*

***"

(emphasis added to show that portion of the statute which the appellants rely upon)

42 U.S.C. § 1396a(a) (17).

The appellants' argument may be correct under what we believe is an overly rigid and literal interpretation of the term "available" under § 1396a(a)(17)(B). We refuse to interpret this statute as equating available with present record title. This would be inconsistent with the approach which is taken under the Medicaid program.

Initially, "we do not lose sight of the [Medicaid] statute's strong emphasis upon flexibility in determining eligibility." *Norman*, *supra*, 610 F.2d at 1240. In another context the Supreme Court interpreted § 1396a(a)(17) as conferring broad discretion on the states to adopt reasonable standards. *Beal* v. *Doe*, 432 U.S. 438, 444, 97 S.Ct. 2366, 53 L.Ed. 464 (1977).[10] The California transfer rule presumes that an asset remains available to an applicant after the applicant has given it away, or sold it for less than adequate consideration. We find nothing in the plain language of this statute which would prohibit such a rule, nor is there anything in the legislative history which equates "available" as requiring present record title or ownership.

To the extent that the regulations address the definition of "available," they support our interpretation. Under the regulations, a state is allowed to examine an applicant's income and assets for a six-month prospective period in determining eligibility. 42 C.F.R. §§ 435.831(a), 435.845(b). Since a state is authorized to consider future assets, it must follow that it should also be allowed to consider those assets which have been recently disposed of under circumstances which indicate that the purpose was to qualify for public medical assistance.

We hold that California's transfer rule does not conflict with 42 U.S.C. § 1396a(17)(B).

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[10] The Supreme Court was considering the extent of medical assistance which the states were required to provide. *Beal*, *supra*, 432 U.S. at 444.

C. *42 C.F.R. § 435.401*

Appellants also claim that the California transfer rule is inconsistent with 42 C.F.R. § 435.401.[11] This regulation provides that a state Medicaid agency cannot use requirements for determining eligibility for the *medically needy* which are "more restrictive" than those used for the *categorically needy*. Since the California transfer rule is a more restrictive requirement, the appellants reason that it therefore violates § 435.401.

While we agree that the California transfer rule imposes a more restrictive requirement on the *medically needy*, we do not believe that § 435.401 has any bearing on the validity of financial eligibility requirements such as the transfer rule.

First of all, if we were to give § 435.401 the broad reading attributed to it by the appellants, we would be reading an inconsistency into the federal statutory and regulatory framework. The Medicaid program is designed to provide benefits to two differently situated groups. The *medically needy* are those individuals who have more available income and resources than the *categorically*

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[11] This regulation provides as follows:

"(a) A medicaid agency may not impose any eligibility requirement that is prohibited under title XIX of the Act.

"(b) The agency must base any optional group covered under subparts B and C of this part on reasonable classifications that do not result in arbitrary or inequitable treatment of individuals and groups and that are consistent with the objectives of title XIXX.

"(c) *The agency must not use requirements for determining eligibility for optional coverage groups that are–*

"(1) For families and children, more restrictive than those used under the State's AFDC plan; and

"(2) *For aged, blind, and disabled individuals, more restrictive than those used under SSI,* except for individuals receiving an optional State supplement as specified in § 435.230 or individuals in categories specified by the agency under § 435.121."

(emphasis added to show that portion of the regulation which the appellants rely upon)

42 C.F.R. § 435.401.

needy. By definition, different financial requirements apply to the *medically needy* than to the *categorically needy*. Only when § 435.401 is read as not applying to financial requirements, such as the transfer rule, can it be viewed consistently with the other Medicaid statutes and regulations.

After all, § 435.401 is merely one of five sections under the general heading entitled: "*Subpart E—General Eligibility Requirements.*" There is absolutely no discussion of financial eligibility requirements in any of the other sections of this subpart. Instead, the focus of all of the sections is directed toward much more general concerns, such as eligibility requirements which are based on citizenship, alienage, or state residence. In addition, a thorough reading of the statutes and regulations shows that the sections of Subpart E parallel the subsections of 42 U.S.C. § 1396a(b). From this it is apparent that Subpart E (including § 435.401) was designed to carry out the statutory mandate of 42 U.S.C. § 1396a(b) which does not involve financial eligibility requirements. *See, e.g., Pacific Coast, supra*, slip op. at 2526.[12] And finally, there are three specific subparts which cover the financial eligibility requirements. Subpart G states the general financial eligibility requirements, Subpart H states the financial eligibility requirements for the *categorically needy*, and Subpart I states the financial eligibility requirements for the *medically needy*. These specific and detailed guidelines for financial eligibility requirements must control over the general rule of § 435.401.

We conclude that 42 C.F.R. § 435.401 does not apply to financial eligibility requirements and therefore there is no conflict between it and the California transfer rule.

D. *Due Process*

In their opening brief, the appellants claim that the transfer rule creates a rebuttable presumption in violation

[12] In *Pacific Coast, supra*, this court noted that "[e]xisting regulations must be construed in light of the statutory mandates under which they issue." Slip op. at 2526.

of the due process. In their reply brief, the appellants call it an "effectively" irrebuttable presumption. We disagree with either characterization and find that the transfer rule creates a rebuttable presumption which is permissible under the due process clause.

The California transfer rule obviously does not create an irrebuttable presumption. After all, the regulations expressly provide that the presumption may be overcome by evidence that the applicant had adequate resources for support and medical care at the time of the transfer of property. 22 Cal. Admin. Code § 50409(b)(2). Such a determination can be based on "such things as the applicant's . . . age, health, life expectancy, and ability to understand [the] extent of [his or her] resources." *Id.* This would mean that if a person was in good health at the time of the transfer, then the presumption might be rebutted because the person would have no reason to anticipate any large expenditure for medical care and support.

The appellants argue that it is an "effectively" irrebuttable presumption because the applicant is precluded from relying on his or her subjective intent. According to the appellants, this excludes the two most likely explanations for this type of transfer, which are: (1) the applicant was unaware of Medi-Cal benefits, and/or (2) a desire to avoid probate. While the state could have considered these subjective considerations, we cannot say that the failure to do so creates a due process violation. California's objective test for determining how the presumption can be overcome does not create an effectively irrebuttable presumption which might run afoul of the due process clause.

E. *Equal Protection*

The appellant's final argument is based on equal protection grounds. They claim that there is no rational basis for treating the *medically needy* any differently from the *categorically needy*. According to the appellants, the *medically needy* are in the identical situation as the *categorically needy*, that is, in need of medical care and without sufficient income or resources to pay for it. Since the "transfer of assets" rule only applies to the *medically*

needy, the appellants argue that it violates the equal protection clause because there is no reasonable basis for the disparate treatment between the two groups.

We fail to see how the application of the transfer of assets rule to the *medically needy* group gives rise to even a colorable constitutional claim under the equal protection clause.

Initially, we note that the two groups are not identically situated. By definition, the *categorically needy* have less income and resources than the *medically needy*. Furthermore, Congress has obviously viewed the two groups differently, or, at least, as not being identically situated. Why else would Congress have left the decision to provide benefits to the *medically needy* entirely up to the individual state? It must be remembered that the *categorically needy* receive benefits regardless of whether a state adopts a medicaid program under Title XIX. However, the *medically needy* only become entitled to benefits if a state first adopts a program, and, secondly, if the state elects to include the *medically needy* group in its benefit program.

In addition, California has a rational basis for its transfer rule. California is confronted with two competing interests, the protection of a limited public treasury, and the provision of benefits to those who are in need. The transfer rule was a reasonable response to these conflicting concerns. Under the rule, benefits are provided to those individuals who, in fact, have a financial need, and benefits are denied to the individuals who have artificially created a need by disposing of assets for less than fair consideration.

We hold that California's transfer rule is rationally related to the legitimate government objectives of protecting the public treasury and discouraging intentional impoverishment so as to qualify under a public assistance program. Any disparate treatment resulting from the application of the rule is sufficiently rational to be upheld against appellants' equal protection challenge. *See Dandridge, supra*, 397 U.S. at 471; *Richardson* v. *Belcher*, 404 U.S. 78, 83–84, 92 S.Ct. 254, 30 L.Ed.2d 231 (1972); *Sims* v. *Harris*, 607 F.2d 1253 (9th Cir. 1979).

III. Conclusion

In upholding the California's transfer rule, we recognize that the majority of the courts which have been faced with similar challenges have reached the opposite conclusion. *See, e.g., Caldwell* v. *Blum*, F.2d No. 79-7864 (2d Cir. April 10, 1980); *Fabula* v. *Buck*, 598 F.2d 869 (4th Cir. 1979); *Udina* v. *Walsh*, 440 F.Supp. 1151 (E.D. Mo. 1977); *Buckner* v. *Maher*, 424 F.Supp. 366 (D. Conn. 1976), *aff'd* 434 U.S. 898, 98 S.Ct. 290, 54 L.Ed.2d 184; *Owens* v. *Roberts*, 377 F.Supp. 45 (M.D. Fla. 1974); *contra*, *Rinefierd* v. *Blum*, 412 N.Y.S. 2d 526 (App. Div. 1979); *Lerner* v. *Division of Family Services*, 235 N.W. 2d 478 (Wis. 1975). Nevertheless, for the reasons stated in this opinion, we are convinced that our analysis of the question is correct.

AFFIRMED.[13]

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[13] Appellants also ask this court, providing they prevail on this appeal, to grant the full measure of relief requested in their complaint and provide notice to all classmembers. Because we affirm the district court, it is unnecessary for us to address the propriety of this request.

IN THE UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

ROSSYE DAWSON, INDIVIDUALLY AND ON BEHALF OF ALL OTHERS SIMILARLY SITUATED, PLAINTIFF-APPELLANT,

vs.

BEVERLEE A. MYERS, ET AL., DEFENDANTS-APPELLEES.

Before: WRIGHT AND ANDERSON, Circuit Judges, and SOLOMON,* District Judge.

The panel as constituted in the above case has voted to deny the petition for rehearing and to reject the suggestion for a rehearing en banc.

The full court has been advised of the suggestion for en banc rehearing, and no judge of the court has requested a vote on the suggestion for rehearing en banc. Fed. R. App. P. 35(b).

The motion of the Secretary of Health and Human Services for permission to file an amicus curiae brief is DENIED.

The petition for rehearing is denied and the suggestion for a rehearing en banc is rejected.

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* The Honorable Gus J. Solomon, Senior United States District Judge, District of Oregon, sitting by designation.

In the Supreme Court of the United States

No. 80-5303

ANTONIA BELTRAN,
PETITIONER

v.

BEVERLEE A. MYERS, INDIVIDUALLY AND AS DIRECTOR, CALIFORNIA STATE DEPARTMENT OF HEALTH, ET AL.

ON PETITION FOR WRIT OF CERTIORARI to the United States Court of Appeals for the Ninth Circuit.

On Consideration of the motion for leave to proceed herein *in forma pauperis* and of the petition for writ of certiorari, it is ordered by this Court that the motion to proceed *in forma pauperis* be, and the same is hereby, granted; and that the petition for writ of certiorari be, and the same is hereby, granted limited to Question 1 presented by the petition.

November 3, 1980

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